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# **What happens to psychological depth in brief-term therapy with trainee therapists? Clients' experiences of therapy and the therapeutic relationship using Interpretative Phenomenological Analysis (IPA)**

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Submitted in partial fulfilment of the requirements for the Doctorate in  
Counselling Psychology and Psychotherapy by Professional Studies  
(DCPsych).

A joint programme of Middlesex University and Metanoia Institute

**2014**

## **ACKNOWLEDGEMENTS**

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To my family, friends, colleagues and supervisors who have supported me in this endeavour, my heartfelt thanks for their love, interest, help and encouragement. To those practitioners who assisted me in finding participants for my research, my sincere thanks for helping me in this way. And finally to the participants themselves, my deepest gratitude for volunteering and for the candour and honesty with which they contributed so generously to my research.

# **What happens to psychological depth in brief-term therapy with trainee therapists? Clients' experiences of therapy and the therapeutic relationship using Interpretative Phenomenological Analysis (IPA)**

## **Abstract**

The purpose of this doctoral research project was to explore the conscious and subconscious thoughts and feelings clients had about their experience of brief-term therapy and the therapeutic relationship. The methodology chosen was IPA because it examines in systematic detail the complex understandings from individuals' making sense of a phenomenon. Face-to-face semi-structured interviews were conducted individually with 10 clients who had recently ended their therapy with trainee integrative practitioners at one low-cost counselling agency. To reach psychological depth, an 'object-tray' of miniature objects was used in each interview to facilitate access to clients' intrapsychic and intersubjective processes, and to trigger metaphorical thinking. Findings detail a wide range of clients' multi-faceted fears and thoughts, and reveal how these relate to client negativity, defensiveness and resistance. They demonstrate how clients were active in overcoming their fears (or not!) and illustrate how clients reflected upon their therapeutic relationships. This study also offers clients' perceptions of various helpful interventions found to be therapeutically successful for reducing fears, and for facilitating psychological recovery and personal growth. The impact of this study could influence assessment procedures, and therapeutic practice and trainings by helping assessors and therapists develop their skills in demystifying therapy for clients and addressing client fears; it could also potentially help to understand the reasons for drop-outs. Furthermore, this study emphasises the need for therapists to obtain client feedback both early on and continually throughout the course of therapy and for therapists to work collaboratively according to clients' needs and wants. However it must be recognised that, as this was small scale research carried out in one particular location, it is possible that another group of ex-client participants would have different sense-making narratives and another researcher might have responded differently in the interview process, perhaps drawing out different data with correspondingly different considerations.

## Contents

Abstract .....	3
1. Introduction .....	6
1.1 My philosophy as a practitioner and personal reflection .....	6
1.2 My philosophy as a researcher.....	7
1.3 Introduction to my research .....	8
2. Literature Review .....	10
2.1 Common factors.....	10
2.2 Therapist and relationship factors .....	10
2.3 Client factors .....	16
2.4 Client experience and units of analysis .....	20
2.5 Research using client voices .....	22
2.6 Research aim and questions .....	23
3. Methodology .....	24
3.1 Rationale for a qualitative approach .....	24
3.2 Rationale for qualitative studies in client experiences research .....	25
3.3 Rationale for Interpretative Phenomenological Analysis (IPA) .....	26
3.4 Accessing out-of-awareness processes and generating metaphors .....	27
3.5 Design .....	28
3.5.1 Sampling strategy .....	30
3.5.2 Interview design .....	31
3.5.3 Reflecting on the interview process .....	33
3.5.4 Ethical considerations.....	34
3.6 Method of analysis .....	36
3.7 Trustworthiness and Rigour.....	40
4. Findings.....	42
4.1 Analysis of Themes .....	44
Superordinate Theme 1: Therapy as dangerous .....	44
Superordinate Theme 2: Feeling safe and understood .....	50
Superordinate Theme 3: Journeying together for Personal Discovery and Change.....	58
4.2 Examples of the impact of my enquiry method and the research relationship.....	69
5. Discussion.....	72

5.1 Overview .....	72
5.2 Clients' thoughts and feelings before entering therapy.....	72
5.3 Clients' thoughts and feelings when first meeting their therapist.....	76
5.4 Clients' descriptions of their therapeutic relationship as therapy progressed .....	80
5.5 Trust and Collaboration .....	84
5.6 Ruptures and Deference.....	85
5.7 When therapy 'takes' – Judging success in terms of ongoing process .....	86
5.8 Symbolism and Metaphor .....	87
5.9 Methodological Aspects for Discussion.....	90
5.9.1 The impact of my enquiry method .....	90
5.9.2 The impact of the research relationship .....	91
Brief-term versus long-term therapy .....	93
Ethical and practical difficulties.....	94
Limitations, future research and implications .....	96
Implications for training, clinical practice and services .....	97
Conclusion .....	100
References.....	101

## Appendices

Appendix 1 Client information sheet.....	111
Appendix 2 Consent form .....	114
Appendix 3 The Object tray .....	115
Appendix 4 Demographics of participants.....	116
Appendix 5 Interview schedule .....	117
Appendix 6 Ethical approval .....	118
Appendix 7 A section of Roza's transcript showing codings and emergent themes .....	119
Appendix 8 A section of Kira's transcript showing codings and emergent themes .....	121
Appendix 9 Table of 89 emergent themes .....	123
Appendix 10 The 89 emergent themes grouped into 7 clusters .....	124
Appendix 11 Example of excerpts of themes taken to peers for validity checks.....	125
Appendix 12 Development of superordinate themes and related themes.....	126
Appendix 13 Master table of themes and transcript location by each participant .....	127
Appendix 14 Selected quotations for theme 1.1 from participants' transcripts .....	129
Appendix 15 Selected quotations for theme 2.3 from participants' transcripts .....	130
Appendix 16 Superordinate theme 1 quotations used in body of work .....	131
Appendix 17 Summary of the Audit Trail.....	133

## Tables

Table 1. Superordinate themes and themes linked with interviewees' experiences.....	43
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## **1. Introduction**

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As counselling psychologists we are practitioner-scientists and our aim in research is to make a contribution both to the current practice and conceptual fields of counselling psychology and psychotherapy, by demonstrating not only what works in therapy but also by finding ways of improving the effectiveness of the psychotherapy we offer. Counselling psychology is therefore an applied psychological science influenced not only by human science research but also by the principal psychotherapeutic traditions. “[It] draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology ... to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship” (British Psychological Society, 2005, p.1).

### **1.1 My philosophy as a practitioner and personal reflection**

As an integrative psychotherapist my approach, grounded in humanistic philosophy, is reflexive, relational and informed by psychodynamic, existential, developmental, neuroscientific and psychological theories. I hold and apply the humanistic values that prioritise client subjectivity and intersubjective experiencing, with the aim of facilitating growth, self-actualisation and empowerment within clients, whilst appreciating the uniqueness of each client and honouring a non-hierarchical relationship (Orlans and van Scoyoc, 2008; Cooper, 2009). And as a practising psychotherapist, I know that each person in the therapeutic relationship brings their own history, personality, attitudes, beliefs, coping mechanisms and unconscious into the therapeutic encounter and much that transpires in the relationship happens below the level of conscious awareness. Correspondingly, my other roles in life which include being a wife, mother, sibling, daughter, aunt and, formerly, an actor, will also be part of the intersubjective mix with another.

My career as a psychotherapist started later in life and part of the course was to be in personal psychotherapy for the duration of the five-year training. I remember being both excited and apprehensive about the prospect. As this was my first therapy, I kept a personal diary about my experience for a year, to remind me what it is like for someone entering therapy for the first time. Perhaps it was this that planted the seed for my research.

## 1.2 My philosophy as a researcher

Aiming to explore human experience of a particular phenomenon, and because of my training, epistemologically I align myself with the hermeneutic phenomenological philosophers such as Husserl, Heidegger and Merleau-Ponty, who were concerned with existence, human nature, and being-in-the-world. They claim that we all have an embodied sense of self which is always in relation to others, while our consciousness is shared with others through language, discourse, culture and history. Phenomenological researchers therefore have a central concern “to return to embodied, experiential meanings aiming for a fresh, rich description of a phenomenon as it is concretely lived” (Finlay and Evans, 2009, p.6) so that the reader of the research can have a better understanding of what it is like for someone to experience that phenomenon. Unlike Husserl who thought that one could find the essence of an experience in the description only, Heidegger (1962) considered that it was from the interpretation of the description that meaning was revealed.

In contrast to phenomenological researchers who are required to bracket previous understandings and assumptions in order not to bias the investigative process, hermeneutic phenomenological researchers consider that self-reflections are inherent and essential to the interpretive process. This situatedness demands explanations of how the researcher’s experience and position relates to the issues being researched (Gadamer, 1976;1988). I am therefore influenced by researchers who use reflexivity as part of the process of constructing knowledge (e.g. Etherington, 2004; Finlay, 2011). Inevitably each reflexive researcher brings a different degree of reflexivity to their research but it is important not to “privilege the researcher over the participant” (Finlay and Evans, 2009, p.121). Finlay suggests that as knowledge “is born within the *between* of the researcher-co-researcher encounter where they intermingle” (2011, p.166) this parallels the therapist-client dialogic process. Thus, epistemologically I position myself as a critical realist, reflexive, phenomenological researcher incorporating interpretivist methodology. This stance is in accordance with the philosophy and ethos of counselling psychology that supports the development of phenomenological research.



### **1.3 Introduction to my research**

Meeting a therapist for the first time is especially anxiety provoking and for many people embarking on a course of therapy this may be a completely unfamiliar and strange experience. As such, many fears, ideas and expectations about the therapist and the therapeutic process will be generated in the minds of clients. Some of these will be conscious while other thoughts will be out-of-awareness and as a result, particular habitual mental processes and learned behavioural patterns may be triggered and possibly enacted before and during their therapy.

This phenomenon, commonly known as “transference”, was originally coined by Sigmund Freud (Breuer and Freud, 1893-1895) to explain the repressed and conflicted unconscious processes related to childhood relationships that are replayed by a client towards his/her therapist in psychoanalysis. Over time, other explanations of transference and counter-transference phenomenon have developed, such as the humanistic and existentialist perspectives that both conceptualise transference, not as duplication of repressed responses but rather as ubiquitous and emerging appropriately in the moment in response to the therapist, the therapist’s attitude and the therapeutic process (Shlien, 1984; Spinelli, 2005). Both these perspectives are validated by neurobiological and cognitive evidence indicating that the brain works by comparing, categorising and generalising events with previous knowledge for anticipation of the next action (Siegal, 1999). This mental process of comparing and categorising appears to be performed unconsciously and within milliseconds. Any new experience will therefore trigger a range of different mental associations, and how this experience is categorised will be affected by the strength of our emotional arousal. In cognitive terms, transference is understood as an adaptive mental function linking the neurobiological processes of learning, memory, emotion, attachment and perception (Pincus, Freeman and Modell, 2007). Currently, the neuroscientific perspective holds that transference and countertransference are therefore neuro-chemical activations of primitive implicit processes located in the right hemisphere of the brain; part of our procedural and autobiographical memory and linked to our emotions (Schore, 2003; 2010).

Although there is an extensive body of literature on the subject of transference predominantly in psychoanalytic literature and in particular with long-term therapeutic work, there still remains a deficiency in looking at the nonconscious and unexpressed dimension in brief-term therapy using qualitative methodology with non-selected representative populations and, more particularly, in studies that focus on the client’s perspective (Tinsley, Bowman and Ray, 1988; Gordon, 2000).

For my doctoral research I wanted to step into this gap and broaden my understanding of psychological depth in brief-term therapy by using a sample that is representative of the local population and also to give those clients a voice. I particularly wanted to explore the underlying processes that were operating during participants' therapeutic experiences such as the unarticulated thoughts and feelings clients had about therapy and their therapist and the kinds of transferences and countertransferences occurring during the therapeutic encounter. As my research focuses on clients' experiences of therapy and the therapeutic relationship, it therefore sits within the field of research into the common factors of psychotherapy. I will start my discussion by briefly outlining where common factors research stands currently, move onto considering therapist, relational and client factors research and how this links with my study, before finally presenting the rationale and methodology of my study.

## **2. Literature Review**

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### **2.1 Common factors**

In the past, common factors have been conceptualised in many different ways and now, after decades of research using meta-analyses statistics, the most recent model showing therapeutic outcome percentages of total variance suggests that: 8% of outcome variance is given to treatment, 12% to relationship, 7% to the therapist, 30% to client's contribution whilst 43% goes to unexplained and other factors (Lambert and Ogles, 2004).

Common factors are currently regarded as encompassing both the persons of the therapist and client as well as the interactive relationship and the treatment. There is substantial evidence that the interaction between the therapist, client and the therapeutic relationship mediate treatment outcome. It is understood that some specific techniques may also contribute to outcome depending on the individual client (Chambless, 2002). The suggestion made is that these common and specific factors are so interlinked that individual contributions cannot be separated and that, in essence, it is through the quality of the therapeutic relationship that interventions are either effective or not (Butler and Strupp, 1986).

Three criticisms levelled against common factors research are: firstly, that it is not as scientific as the medical model, secondly, although the factors are necessary they are not sufficient without the specific treatment, and thirdly, the proportions may not be similar across all forms of psychological distress (Chambless and Ollendick, 2001). At the moment common factors can only give us a global assessment of how each of the factors contributes to psychological change and they neither specify the particular processes involved nor how they interact with each other. My research aims to address this gap and enhance our knowledge by exploring some of the conscious and unconscious processes that operate within the therapeutic encounter and how these impact the therapeutic relationship and client psychological change.

### **2.2 Therapist and relationship factors**

The evidence for what therapists bring to therapeutic encounter and how they affect outcome seems to confirm that variations exist in the effectiveness of individual therapists (Ricks, 1974; Okiishi, Lambert, Nielsen et al., 2003), even when those therapists were working within one

particular orientation (Luborsky, Singer, Woody et al., 1985). However, a major limitation of this body of research was the inability to explore the interpersonal characteristics that may have been involved in the outcome. With regard to therapist age, gender and personality, Beutler and colleagues found fewer successful outcomes when therapists were ten or more years younger than their clients and it made no difference whether therapist-client dyads were similarly gendered (Beutler, Blatt, Alimohamed et al., 2006). Although clients reported that the personality of the therapist was an important aspect in therapy (Sloane, Staples, Whipple et al., 1977) there is no empirical evidence linking therapist personality traits with greater or lesser success of outcome. The indications are, rather than therapist personality *per se*, it is the therapist's relational style and interpersonal qualities that relate more strongly to beneficial outcome (Lambert and Ogles, 2004; Tallman and Bohart, 2008); as well as their skill and credibility (Orlinsky, Rønnestad and Willutzki, 2004).

Recently, a task-force of experts used meta-analyses on all the evidence-based research in their individual divisions to investigate what works in the therapeutic relationship (Norcross, 2011). Norcross and Lambert (2011) define the relationship as "the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (p.4). Findings revealed that therapist empathy (Elliott, Bohart, Watson et al., 2011), positive regard (Farber and Doolin, 2011) and congruence (Kolden, Klein, Chia-Chiang et al., 2011) are necessary in order to develop a therapeutic alliance. These components constitute three of the six of Carl Rogers' (1951) core conditions that underpin his humanistic approach; and moreover, Rogers placed great emphasis on the importance of the client actually perceiving these processes emanating from the therapist. Interestingly, research found that clients who had non-relationally oriented therapies such as behavioural therapy or CBT consistently rated the relationship with their therapist as more helpful than the actual techniques (Ryan and Gizynski, 1971; Kiegers, Schaap and Hoogduin, 2000), emphasising that the important factors were therapist empathy, positive regard, calm and sympathetic listening, approval and support. Based on these concepts and findings, it would be interesting to produce a study that offers detailed verbatim descriptions of how clients articulated their experience of receiving brief-term therapy from integrative therapists grounded in the humanistic approach and additionally to find out what aspects of their therapist affected them.

Another component considered to be a crucial part of the therapeutic relationship is the working alliance although there has been much debate in the past on what concepts actually constitute the alliance. The revised alliance theory now emphasises that it is "the active collaboration between the participants" (Horvath, Del Re and Symonds, 2011, p.27) that creates the therapeutic working

space for beneficial outcome. The therapist needs to be able to create a safe, secure environment enabling a non-transferential bond (Bordin, 1975) to form in the first moments of therapy that will further deepen into a 'real relationship' (Moore and Gelso, 2011). It is suggested that the real relationship can be formed in the first moments of therapy (Moore and Gelso, 2011) and findings have demonstrated that a positive relationship by the third session of therapy relates to successful outcome (Marmarosh, Gelso, Markin et al., 2009); whereas attachment bonds take at least five sessions to develop (Mallinckrodt, Porter and Kivlighan, 2005). Moreover, evidence derived from meta-analyses indicates the earlier in therapy (i.e. within the first four sessions) that a good alliance is established, the more successful the outcome, especially for brief therapy (Horvath and Symonds, 1991). Since there is more brief therapy being conducted in mental health care, it therefore seems vital that trainees and practitioners can achieve a therapeutic alliance quickly with their clients. I am interested in addressing this, as exploring clients' perceptions of the formation of a therapeutic alliance would enhance our understanding of this process.

A mixed-methods study on how clients experienced brief cognitive therapy for depression, and their explanation for how change came about, found clients reporting that feelings of safety, being understood and a collaborative relationship were important factors that enabled engagement in the therapeutic work (Clarke, Rees and Hardy, 2004). This collaboration requires both therapist and client reaching agreement on the goals and tasks of therapy as well as working together on these tasks and goals (Bordin, 1975; Cooper and McLeod, 2011). This is clearly an important area of research as meta-analysis of over 1,000 research findings indicates that both a positive alliance and clients' active participation in therapy are possibly the most important determinants of successful outcome (Orlinsky, Grawe and Parks, 1994; Orlinsky, Rønnestad and Willutzki, 2004); and that client ratings of the alliance predict outcome better than therapists' ratings (Bachelor and Horvath, 1999). Since client active collaboration is such a significant factor in successful outcome, and client ratings a better predictor of outcome, it seems increasingly important to hear more from clients themselves about what processes enable and impede the establishing of this alliance.

Psychoanalytic theorists have long believed that the unconscious plays a huge role in personal interactions. From the moment of contact between therapist and client there is an exchange of verbal and nonverbal communications (e.g. body movement, facial expressions, eye contact, vocal inflections, tone and rhythms etc.) (Gelso and Carter, 1985). Much support for unconscious interpersonal processes comes from neuroscientific evidence demonstrating not only that the right hemisphere unconsciously processes facial and auditory cues in milliseconds, but that this

hemisphere has strong links to our limbic system, the area of emotional processing (Schore, 2003). Clinicians and theorists propose that both participants in a therapeutic encounter, each with their own contexts and personal and interpersonal histories meet and interact intersubjectively in a “continual flow of reciprocal mutual influence” (Stolorow and Atwood, 1992, p.18) and mutuality (Mitchell and Aron, 1999).

As client and therapist interact, the intersubjective dynamics change accordingly, affecting both client’s and therapist’s empathic attunement, and the way the therapist subsequently responds to the client. Research indicates that the more willing a client is to collaborate in therapy the more empathic the therapist becomes (Elliott, Bohart, Watson et al., 2011). Whilst pure intersubjectivist clinicians emphasise unbroken therapist empathy, relational therapists also use challenge and self-disclosures as part of their repertoire, judiciously sharing their thoughts and feelings for the benefit of their client (DeYoung, 2003). Not only do these intersubjective processes between therapist and client explain why, in the common factors model, client factors cannot be totally separated from the co-created dynamic therapeutic relationship and therapist factors, but they also emphasise the complexity of the therapeutic relationship with its multi-layered processes. Studies that can uncover some of the subjective and intersubjective processes operating in the therapeutic encounter, and especially from the client’s perspective, would deepen our understanding and benefit clinical practice.

Leading researchers in the field of relationship and effective therapy (Cooper and McLeod, 2007; Cooper, 2008; Norcross and Wampold, 2011) now advocate tailoring therapy to suit individual needs. But because evidence has demonstrated that therapists can wrongly perceive what is significant (Timulak, 2010) and consistently under-rate the quality of their relationship with their clients (Tyron, Blackwell and Hammel, 2007a), the researchers propose that a good therapeutic alliance can only be achieved through a mutual collaborative engagement, requiring constant monitoring by a responsive and adaptable therapist. Therapists need to be both sensitive and delicate in their negotiations with their clients, encouraging clients to offer feedback on themselves, their therapy and the therapeutic relationship throughout the whole process; as well as reporting on whether their goals are being met (Tryon and Winograd, 2011).

Also interesting to note is evidence suggesting that clients can become worse when therapists adapt therapy to individuals’ needs with some clients feeling that an informal therapeutic style lacks professionalism (Schulte, Kunzel, Pepping et al., 1992). In answer, Stiles, Honos-Webb and Surko (1998), propose that therapists need to be appropriately responsive to their clients by being sensitive to client requirements, monitoring their clients’ responses to their interventions and

changing their therapeutic strategies better to suit individual client wants and needs. They define responsiveness as non-linear but circular, “a dynamic relationship between variables, involving bi-directional causation and feedback loops” (p.438) - an implicit intersubjective dynamic. Thus there is abundant evidence to suggest that effective therapists need to be prepared to adapt their relational stance and methods in response to clients’ feedback (Norcross and Lambert, 2011), as well as staying open and responsive. A therapist grounded in an integrative approach has no allegiance to any one particular psychotherapeutic model and therefore can work in a more flexible manner. I would be interested to find out whether clients found their integrative therapists to be adaptable to their needs and wants, and discover to what extent these clients were able to give feed-back and collaborate in their therapy. Any weaknesses found in this area from participants’ accounts can then be relayed back and addressed in therapist training.

Many clients who enter therapy are difficult to work with and this can set up countertransferences in the therapist. Research in countertransference is difficult to assess empirically because of its ‘unconscious’ nature and complexity, and current thinking suggests that it needs to be looked at more holistically. The meta-analyses carried out so far have not found empirical support for linking countertransference behaviour and outcome, except that therapists’ negative countertransference behaviour affects the therapeutic alliance adversely and this therefore can affect outcome (Hayes, Gelso and Hummel, 2011). Overall findings from both quantitative and qualitative studies indicate that countertransference, being a universal phenomenon, negatively affects outcomes only if therapists collude or enact rather than use their countertransference reactions to deepen their understanding of the clients (Hayes, Gelso and Hummel, 2011). Using clients’ or therapists’ ratings of transferences and countertransferences have been found to be problematic, so experienced external judges were employed to judge practitioners’ transference behaviours (Friedman and Gelso, 2000). But this is a one-removed position and perhaps by using a more holistic and creative methodology it might be possible to facilitate clients to access some unconscious processes that happened in their therapy and to reveal any negative emotions they had felt towards and radiating from their therapists.

Decades of research have found that it is also important that ruptures in the therapeutic relationship are repaired, as this strengthens the alliance and links to successful outcome; conversely, weak therapeutic alliances correlate with unilateral termination (Safran, Muran and Eubanks-Carter, 2011). Ruptures can be due to disagreement about the tasks and goals of therapy as well as strains or breakdowns in collaboration, understanding, communication or therapist empathy. As a consequence the client can feel criticised, patronised or misunderstood. Safran and colleagues suggest that the therapist needs to be sensitive to the subtle indications

of ruptures and repair them empathically and non-defensively, with acceptance of their part in the process, although caution and care is especially needed if trying to make a link between the here and now relationship and external relationships. Additionally, clients have reported it helpful when they are encouraged by their therapists to explore ruptures (Safran, Muran and Eubanks-Carter, 2011). A qualitative enquiry using clients' first-hand accounts might reveal detailed experiences of any ruptures and repairs. As a researcher, I am curious to see whether participants would be willing to discuss negative elements of their therapy and/or the therapeutic relationship with me. There is evidence that in the past clients have shown deference towards their therapists and been reluctant to discuss any negativity about their therapy with their therapists (Rennie, 1994a) and this deference may be reflected in a research interview with clients wishing to protect their therapist. However, as relational therapists are trained to invite feedback from their clients, deference may not be so common now, and this therefore would be an interesting area for further research.

Clinically, this concept of a sensitive, relationally-tuned versatile therapist who can adapt their therapeutic practice to suit each individual client whilst holding an ongoing awareness of the countertransference responses is, in fact, an integrative approach which stresses aspects of overt collaboration between the therapist and the client (Evans and Gilbert, 2005). Therapist inter-relational skills both on conscious and unconscious levels are deemed crucial in this multi-dimensional approach, as evidence suggests that it is through a trusting, secure, responsive relationship that the therapeutic methods and ideas communicated by the therapist will be accepted by the client (Hubble, Duncan and Miller, 2008; Norcross, 2011). No research has yet been carried out on how clients experience their therapy with integrative trainee therapists who are involved in a training that is heavily weighted towards the relational from the start, and it would be interesting to see whether this stance is perceived by their clients. Having a study of clients' accounts of their subjective and intersubjective experiences may also reveal some facets of understanding about the therapeutic relationship that can then be relayed back into the training.

In summary, there is abundant evidence that all these therapist and relationship factors have individually been found to be associated with successful outcome, with research now indicating that "an effective psychotherapist is one who employs specific methods, who offers strong relationships, and who customizes both treatment methods and relationship stances to the individual person and condition" (Tallman and Bohart, 2008; Norcross and Lambert, 2011). The idea that therapists should be looking at the therapeutic engagement in a more holistic and adaptive fashion using a range of different therapeutic approaches and interventions parallels the pluralistic ideas of leading researchers, Cooper and McLeod (2007). Current thinking suggests that it would be highly unlikely that one particular therapeutic method would suit everyone, even



those who present with similar symptoms and diagnoses because, as individuals, clients have different histories, needs, wants and understandings and are therefore helped by different therapeutic processes at different times (Castonguay and Beutler, 2006; Wampold, Budge, Laskaa et al., 2011). Since the therapist needs to tailor therapy to the client's personality, culture, preferences, world view, coping-style, stage of change and personality dimension (Norcross and Wampold, 2011) the indications are that researchers should now focus on client factors, widely acknowledged as having been neglected in the past (Gordon, 2012).

### **2.3 Client factors**

Although the 'dodo bird verdict' of therapeutic equivalence (Rosenzweig, 1936; Luborsky, Singer and Luborsky, 1975) means that, in whatever therapeutic modality they engage clients tend to have similar outcomes, indications are that client characteristics make a significant contribution to therapeutic success; i.e. 30% of total outcome variance (Lambert and Ogles, 2004). "[I]t is the client more than the therapist who implements the change process. If the client does not absorb, utilize, and follow through on the facilitative efforts of the therapist, then nothing happens" (Bergin and Garfield, 1994, p.825). Since personal change depends on how an individual client relates to and engages with therapy, it is imperative that practitioners understand more about what clients bring to and how they experience therapy and this is the reason for my study.

Before entering therapy, people generally use whatever resources they have in overcoming problems; they may self-heal either through self-help books (den Boer, Wiersma and van den Bosch, 2004) or through talking to friends, family and colleagues (Tallman and Bohart, 2008). It is only when people are unable to overcome their difficulty or distress through these methods that they might turn to therapy for help, perhaps as an alternative to seeking medical assistance. However, not everyone who enters therapy comes with positive and realistic expectations.

Quantitative studies suggest that there are many different factors involved in clients' expectations of a successful outcome in therapy. One study of therapists' perceptions not only found that clients held unrealistic positive or unrealistic negative expectations that impacted their therapy on different levels but the findings also indicated that clients do not have a clear realistic idea of how therapy works, what the therapist's role is and what is required from themselves as clients (Tinsley, Bowman and Barich, 1993). Awareness of what is required in the role of the client and what is expected from the therapist has thrown up differences with different groups. For example, New Zealand clients were unaware that therapy required them to be active participants in the discussion and collaboration of their treatment, expecting instead, to take a more passive role

whilst conversely, American clients did expect to take an active role in their therapy (Deane, 1992). In a similar vein, Asian American clients expected and preferred their therapists to be more directive and authoritative (Li and Kim, 2004). Thus there are differences in cultural perceptions of what therapy is and how therapy works, and it would be interesting to see whether these cultural differences still persist.

Whilst findings suggest that a better outcome is achieved when therapists frame their approach to meet their client's expectations, it is also known that clients can be motivated and ready for change and yet hold low expectations that therapy can help them (Constantino, Arnkoff, Glass et al., 2011). A meta-analysis of client expectancy studies found that client hopelessness is linked with negative outcome, although it is not clear what mechanisms are involved; conversely, that although there is an assumption that positive expectations are linked with successful outcome the findings do not strongly support this. Constantino and colleagues (2011) opined that there were too few extant studies to be able to reach a definite conclusion, although they found indications that those who expect a positive outcome are more likely to work collaboratively with their therapist, particularly if they feel that their goals are achievable, and that clients with higher expectations of active involvement in therapy seem to achieve greater changes in *interpersonal* functioning.

Correspondingly, clinicians over the years have posited that hope increases both clients' positive expectations and confidence in the therapeutic process by activating clients' emotional investment in therapy with trust in the therapeutic relationship (Frank and Frank, 1991; Yalom, 1995). Additional empirical support for linking hope with client change has demonstrated that clients need to perceive that their therapist has both hope in the therapeutic process as well as hope that they can change (Snyder, Michael and Cheavens, 1999). This is complemented by a more recent qualitative study, using Kagan's (1980) Interpersonal Process Recall (IPR) method, revealing that when therapists included the use of implicit and explicit hope-focused interventions in their sessions, clients found it augmented their sense of hope and self-awareness, and enhanced their self-esteem and self-identity (Larsen and Stege, 2010b; 2010a). There seems to be a gap in this area of research that needs clarification and I propose that this would be best remedied by a qualitative method that can explore in detail what clients thought and felt about entering therapy and their ability to work collaboratively with their therapist.

Forming and maintaining positive alliances with clients is crucial. Widespread research from client, therapist and relational studies has found that one of the strongest - possibly even the strongest - predictor of outcome is client motivation, openness and engagement in therapy

(Orlinsky, Grawe and Parks, 1994; Seligman, 1995; Tyron and Winograd, 2002; Orlinsky, Rønnestad and Willutzki, 2004; Tryon and Winograd, 2011). But what happens when we have clients who find it difficult to engage and collaborate in therapy? Interestingly, it appears that successful outcome is not dependent on how well clients are able to form a relationship with their therapist, but only on how well the therapist is able to form positive alliances with their clients (Baldwin, Wampold and Imel, 2007). This therefore would put the work of developing an alliance firmly in the hands of the therapist. However, clients holding negative processes make it difficult for therapists to form an adequate alliance to foster a collaborative ambience, as evidence indicates that clients' defensiveness and resistance negatively correlate with outcome (Orlinsky, Rønnestad and Willutzki, 2004).

These defensive processes have been termed resistance and 'reactance'. Resistance is considered to be an intrapsychic sensitivity whereas 'reactance' is a mental state generated by a perceived external threat to self. Both are "active processes driven by a common need to escape the therapist's effort to limit his or her behaviour whether through direct suggestion or via the inherent demands for change within the therapy process" (Beutler, Harwood, Michelson et al., 2011, p.264). Both are deemed to be individual client characteristics that are linked with fear of losing control or freedom, and furthermore it is suggested that these fears are linked to clients' coping styles (Beutler, Harwood, Kimpura et al., 2011), stage of change (Norcross, Krebs and Prochaska, 2011), cultural beliefs (Smith, Domenech Rodriguez and Bernal, 2011) and symptom severity (Beutler, Harwood, Michelson et al., 2011). On the strength of their findings, Beutler and colleagues (2011) suggest a client's resistance or reactance is a problem that is up to the therapist to solve. They recommend that therapists need to adapt their approach and work sensitively with clients to gain their trust and that the best ways of working with these clients is by listening, using reflective feedback and non-directive interventions.

Findings also suggest that clients who have faith in the therapeutic process tend to achieve more than those who are sceptical about therapy (Beutler, Blatt, Alimohamed et al., 2006), and this links with an early review study by Kushner and Sher (1991) who listed a range of fears that cause a barrier against seeking therapy. These fears were of embarrassment, change, treatment stereotypes, previous mental health experience, stigma, and talking about specific problems that will evoke anxiety. At the time, Kushner and Sher stated that these fears were a multifaceted phenomenon that related to gender, age, cultural differences and individual stage of change, which mirrors Beutler and colleagues (2011) understanding of resistance and 'reactance'. Support comes from other studies finding that people avoid counselling and psychotherapy through ignorance and fear (e.g. Millar, 2002; Vogel, Wester and Larson, 2007). However there is little in the literature that offers clients' own accounts of their fears in detail.

Another area of clinical interest, coming from a different perspective, is attachment theory, and the effect that different attachment styles have on the therapeutic relationship (e.g. Holmes, 2001; Beebe and Lachmann, 2002). Although there have been some studies finding that clients with secure attachment styles gain more from therapy than those with avoidant or ambivalent relating styles (Meyer and Pilkonis, 2002; Saatsi, Hardy and Cahill, 2007) there are still relatively too few empirical studies examining how client attachment styles influence outcome for a meta-analysis to be carried out (Levy, Ellison, Scott et al., 2011). Interestingly, unlike others in the insecure attachment category, those with a dismissive attachment style can form good therapeutic alliances and do well in therapy (Meyer and Pilkonis, 2002).

All the findings on client factors and, in particular, fears, defences, avoidance and negativity in clients demonstrate the complexity of this issue and that this is an under-researched area. It highlights the need for us to understand from clients themselves not only why they are resistant or reactant but also the need to gather rich descriptions of their fears and defences and to discover whether, how and why these altered during the course of therapy. A qualitative study that could elicit and explore clients' defences and fears in detail, and furthermore demonstrate how these internal processes influenced clients' interactions with their therapists and the therapeutic process, would make a useful contribution to existing theories and broaden our understanding in this area of research.

If one is to tailor therapy to the individual, one needs to know more about what the client brings to the relationship (Cooper, 2008;2009). Clinically, research indicates that therapists need to be aware of the many interwoven client factors that can interfere with alliance building, with the therapist needing to be responsible in finding ways of being with their clients that reduce client fears and build trust, a particularly difficult process with clients suffering from severe psychological problems such as extreme personality disorders and psychosis (Lambert, Garfield and Bergin, 2004). Since clients differ in what they need and what works best for them, obtaining a better understanding of how clients themselves experience their therapy and what processes thwart their ability to engage fully in the therapeutic process would be advantageous.

Most of the research in this area has been dominated by quantitative methodology and over the years there have been many calls for more qualitative studies to provide detailed information on the actuality of client experiences, the effect of interventions, the inter-subjective processes, as well as offering explanations and meanings of client change (Rennie, 1994e; McLeod, 2001). Encouragingly, this imbalance is being redressed and in the last few years we have seen a developing trend towards using qualitative methodologies that make a valuable contribution to

clinical research and practice. This is advancement as qualitative studies can contribute a richness and depth to existing theories and complement and enhance quantitative research. Furthermore, through the complexity of clients' accounts new understandings and new hypotheses can be generated.

Politically, there is also a need for more research from the humanistic-existential-phenomenological and psychodynamic orientations "because we need to demonstrate the effectiveness of psychotherapy to fundholders, statutory bodies and the outside world" (Weisz, 2012, p.2). To achieve this, more small-scale qualitative studies are required to build an extensive literature base. McLeod (2003), however, makes the point that it would be difficult to compare quantitative outcome measures with qualitative effectiveness research because the two methodologies, being grounded in different epistemologies, would make it impossible to evaluate qualitative data using effect sizes. One solution, he offers, is the possibility of combining the two methods in a complementary fashion. Nevertheless, there is a need for more collaboration between research and clinical practice (Kazdin, 2008), and acquiring a body of literature from rigorous and systematic qualitative research would make for more interesting reading that would reach and inform practitioners (as well as other bodies) as to what makes psychotherapy more effective.

I will now discuss how client experience research can be demarcated with employment of different methodologies, argue the case for client voices, and then set out my research aims and questions.

## **2.4 Client experience and units of analysis**

Elliott posits that client experience can be researched by four units of analyses: global, session, within-session and sub-episode units (Elliott and James, 1989; Elliott, 2008). Quantitative measures can be used after each session or globally, after a course of therapy; and although these provide statistics, the abstraction of knowledge cannot offer rich and detailed accounts about individual subjective experiences and within-session interactions. To obtain this kind of detail, additional qualitative data is needed. Mixed methods studies have therefore been conducted that use both measures and interviews. For example, studies have used specially designed questionnaires plus interviews to assess clients' views of the process and outcome of self-disclosure whilst in longer-term therapy, revealing the complex decision-making that surrounds client self-disclosure and the risks involved in doing so (Farber, Berano and Capobianco, 2004). Using a similar methodology, another study asked clients for their views on

the agency, first impressions of their therapist, and how they viewed the therapeutic process. Findings demonstrated that clients were self-motivated in choosing therapy, and active participants in the therapeutic process. Importantly, they also reported feeling altruistic about participating in the research (Manthei, 2006). However more emphasis was given to feedback about the agency and the service it provided, rather than the processes happening within the therapeutic relationship as therapy progressed, which is where my interest lies.

Studies can also use session and within-session units of analysis. In one qualitative study clients kept diaries about their thoughts within and outside sessions as well as their experiences between sessions. This provided knowledge on how clients made sense of their developing therapy within the context of their daily lives (Mackrill, 2007). Another qualitative study used three interviews (beginning, middle and three months after ending) to explore what clients found helpful in their eight-week course of therapy in a day-treatment centre. Their focus was on how the service could be improved and what kinds of knowledge, gained through therapy, were subsequently transferred into clients' daily lives (Mörtl and Von Wietersheim, 2008). However, neither of these studies was concerned with how clients reflected on their therapy and the therapeutic relationship.

Within-session and sub-episode units have focused on clients' reports of their interpersonal experiences within a brief event, and generally these types of studies use a mixed methods approach. Questionnaires are first used to select particular topics and then an interview follows. Areas of research have focused on the negative and positive aspects experienced by Christian clients with secular therapists (Cragun and Friedlander, 2012) and helpful and significant aspects of therapy (Levitt, Butler and Hill, 2006). Other studies have used questionnaires followed by tape-assisted recall of therapy segments to explore different aspects such as congruence/incongruence (Grafanaki and McLeod, 2002), or to identify which in-session interactions affected clients' sense of hope (Larsen and Stege, 2012). Although advantageous for either focusing on significant factors of therapy or providing within-session unfolding accounts of thoughts and feelings, these methods can only offer us a partial picture of the therapeutic process. They do not provide information on how clients make sense of the totality of their therapeutic experience. Research investigating the whole of an experience can be considered as a global unit of analysis and, although the immediacy of moment-by-moment processes is lost, nevertheless the strength of global studies allows for discovery of connections between events. The few studies that have used global analyses with a homogenous client or therapist group include: experiencing therapy with racially-different therapists, (Chang and Berk, 2009); finding differences in the way clients experienced male and female therapists (Gehart and Randall, 2001); investigating refugees' experiences of trauma therapy (Gilkinson, 2009); and exploring therapists' experiences of personal therapy (Bonsmann, 2010).

## **2.5 Research using client voices**

In the past, research has thrown up discrepancies between therapist and client evaluations. For example, previous quantitative research in the field of client experiences has highlighted that clients have different evaluations of significant moments in therapy, as well as holding more accurate perceptions of their therapy than their therapists; but nonetheless greater emphasis was placed upon the judgement of therapists and external raters (Gurman, 1977; Tyron, Blackwell and Hammel, 2007b; Timulak, 2010). By privileging 'expert' opinion over clients' views, therapists can be misled about what clients actually find important in therapy and what works for them.

And yet there has been reluctance in conducting client interview studies. A review study listed the reasons why researchers shy away from client experience research. These were that researchers believe that clients are unable to make accurate judgements, that client accounts would be psychologically unaware, biased and distorted, that clients would have difficulties with recall, articulation and expression, and moreover the process of obtaining information about the therapeutic experience may open up 'old wounds' (Hodgetts and Wright, 2007).

More recently, qualitative researchers are answering the call to redress this imbalance with increasing interest being shown in gathering client experience data using a variety of methods. The different analytic methods have included, for example, narrative thematic analysis for two clients' therapeutic experiences while suffering with chronic anorexia nervosa (Ross and Green, 2011); narrative analysis for ex-military clients' experiences of therapy (Stack, 2013); grounded theory analysis on clients' self-awareness in response to their therapists' operations using an IPR interview (Rennie, 2006); interpretative phenomenological analysis (IPA) on how clients experience an imposed change of therapist during a course of therapy (Bourne, 2013); and combinations of methods, such as grounded theory and content analysis on what clients thought was helpful about their therapy experiences in a day treatment clinic (Mörtl and Von Wietersheim, 2008).

Conducting interview studies seems vital in order to deepen our understanding about client experiences especially if we consider the findings from both quantitative (Regan and Hill, 1992) and qualitative (Rennie, 1994a) research that demonstrates that clients keep many negative things (i.e. emotional, cognitive and behavioural responses) hidden from their therapists in their efforts not only to be polite, pleasing and protective of the alliance, but also in deference to their

therapists' expertise (Bury, Raval and Lyon, 2007). On the other hand there has been a qualitative study in which participants were able to disclose negative attitudes about their therapy alongside their fears about therapy (M Schoenberg and S Shiloh, 2002). Perhaps it would now be fruitful to obtain more clarity about this and explore in detail what sort of fears and negative attitudes people bring into their therapy.

If we believe that clients are instrumental in self-healing and experts in their own experiences, then we need to hear more clients' voices rather than rely on therapists to provide the information of what happens in therapy. Conducting boundaried interviews and observing client anonymity and confidentiality may produce data hitherto hidden and unknown. We may not gather all the knowledge in client interviews but we may uncover information with additional contextual material that may yield further knowledge about clients' views of their therapy, and their intrapsychic processes and interpersonal interactions. Moreover, through qualitative research, some of the content considered confidential within the confines of the therapeutic session may be given a chance to be disseminated into the public arena, thereby helping to de-stigmatise personal therapy and encourage the public to view engaging in therapy as a courageous act with beneficial rewards.

## **2.6 Research aim and questions**

To the best of my knowledge there is no purely qualitative study that has interviewed self-referring members of the public who have experienced therapy from an independent counselling agency that was not in-house. My research would fill this gap. My aim is to explore how a mixed-gendered group of lay-clients (i.e. not therapists or trainee therapists) experienced their therapy in a low-cost counselling agency with trainee practitioners on an integrative training course. I am curious to find out whether I can access the deeper psychological processes happening within clients such as fears, transferences and counter-transferences, and how these processes impacted the course of their psychotherapy and the relationship they had with their therapist.

My research questions are:

What thoughts and feelings did you have about therapy before you started therapy?

What thoughts and feelings did you have when you first met your therapist?

How would you describe your relationship with your therapist as therapy progressed?



### **3. Methodology**

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#### **3.1 Rationale for a qualitative approach**

As a critical realist I sit along a spectrum between the discourses of traditional science and social science. Accepting a positivist view of a natural world reality consisting of a plurality of structures that generate events, I challenge the deterministic methodology in human science that separates contexts into single variables. I argue for diversity and the use of creative methods to obtain knowledge that are more responsive to complex phenomena, preferring more holistic, pluralistic and comprehensive approaches that incorporate interpretative methods in order to achieve a fuller and more complete understanding. This argument mirrors the current drive in modern science that is showing more interest in understanding interactivity, circular relationships, different levels of organisation and emergent processes (Pilgrim, 1997; Strawbridge and Woolfe, 2003).

I also hold that there is no value-free, objective research and that researcher and participant are interactively linked in the construction of knowledge (Denzin and Lincoln, 2005). This is Husserl's view, founder of the philosophical school of phenomenology, who believed that as we can only experience the world through our senses, we construct and interpret our life-world through our relationship to the objects and things in the world and in our consciousness (Spinelli, 2005). Since we can never have direct access to, or knowledge of the 'real' world as it is, it follows that we can only interpret it through a particular perspective, schema or lens. Therefore understandings and meanings will vary between different people holding different lenses (Gadamer, 1976;1988) and truth, knowledge and reality are created by active interpersonal construction and negotiation of meaning (Yardley, 2000).

Later, Heidegger modified Husserl's conception of phenomenology, contending that humans are more than conscious beings. We are embodied and embedded in the world, and the way we define and respond to phenomena also depends upon our emotions and non-conscious awareness. He posited that, although humans can share experiences, each individual experience will also hold a degree of uniqueness (Spinelli, 2005). Experimental science, by focusing on shared features amongst a population reduces the importance of the unique; phenomenological science, in contrast, prioritises the unique.

Predominantly, as a qualitative researcher, I recognise multiple realities, maintain that local understandings are part of a continuing construction of knowledge and view science as a continual process of exploration and building up our understanding from multiple reasonings and

'little narratives' (Strawbridge and Woolfe, 2003). Furthermore, as ongoing experiences can never be the final statement about phenomena, these meanings will continue to be emergent, partial, imperfect and tentative (Finlay, 2011).

### **3.2 Rationale for qualitative studies in client experiences research**

Decades of efficacy and effectiveness and process and outcome research using quantitative methodology and meta-analyses has given us a corpus of literature of "what works" in therapy, and shown us that common factors interact within the therapeutic relationship (e.g. Lambert, 2004; Norcross, 2011). Yet from Lambert's and Ogles' (2004) common factors revised outcome variance percentages it appears that there is still 43% of outcome variance that is due to unexplained and other factors, indicating that we still do not fully know what other underlying factors influence client outcome. And the more we can uncover about common factors and the interactions within, the more our effectiveness as therapists can be improved.

However, what has been conspicuously absent from most of the extant literature in this field of client experience is the acquisition of a range of small-scale in-depth and richly textured studies using the clients' voice. Whilst there has been a slow trickle of qualitative research over the years, currently there are indications that this is advancing with more researchers developing different qualitative methods for researchers to follow and use in the field (e.g. Etherington, 2004; Charmaz, 2008; Smith, Flowers and Larkin, 2009). Accordingly more qualitative studies are required in order to expand this research base and broaden our understanding about client experience. Although quantitative measures are useful for quantification across a large population sample, small-scale qualitative studies gather detailed accounts from individual clients themselves, supplying context, meanings and richness that cannot be obtained by using pre-defined and fixed-response questionnaires that by their nature can only be superficial. Studies using qualitative methodology bring complex analysed data to research that is equally important as quantitative outcome measures, and furthermore are also more likely to be read by practitioners.

For my study, I wanted to fill a gap in client experience research and use qualitative methodology to explore how adult clients who had self-referred to brief therapy at a low-cost counselling agency experienced their therapy and the therapeutic relationship.

### **3.3 Rationale for Interpretative Phenomenological Analysis (IPA)**

Based on the gaps in the literature and my philosophical stance, my aim was to explore how clients who had recently ended their therapy, made sense of their experience and to capture as closely as possible the way they reflected on their therapy and the therapeutic relationship. I also wanted to give each client a voice so that a sense of the individual comes through to the reader.

Wanting to discover and explore rather than refine and reduce the data as in the Husserlian method of analysis, I disregarded grounded theory methods (Glaser and Strauss, 1967; Charmaz, 2008) that extract essences from the data with which to construct a theory. And whilst thematic analysis could have been an option as it compares and contrasts themes, it likewise aims to build theoretical models from the data (Braun and Clarke, 2006). Methods that focus on theory construction are uninterested in individual continuity and their reductionist bias omits inconsistencies and differences within and across data-sets.

Wishing to interpret the phenomenological descriptions and find meaning from within a particular frame of reference (Heidegger, 1962), I rejected the reductive method of Giorgi's (2008) distillation of essences and purely descriptive analysis. In a similar vein, I felt that narratology might result in superficial and smoothed accounts, as linguistic expressions that indicate deeper processes happening within the individual would be edited out. Derived from social constructionism, narratology is uninterested in the human psyche and individual ambiguities, focusing instead on areas such as the structure (e.g. Gergen and Gergen, 1988) and content (Crossley, 2000) of stories about various events, with the aim of acquiring the essence through finding similarities across data sets. My purpose was to retain the differences and ambiguities of individual accounts so that a range of therapeutic experiences could be described.

I also rejected discursive approaches, such as discourse analysis (Potter and Wetherell, 1987) that, concordant with other constructionist perspectives, focus on how meanings and experiences are socially constructed, and in particular discourse analysis explores the functional and performative effects of language in different social contexts. Instead my aim was to explore individual psychologies; and rather than just let clients narrate their story which might border on the superficial, I chose to use objects as prompts (see below) as I particularly wished to access out-of-awareness thoughts and feelings and capture metaphorical imagery.

I preferred IPA as a methodology since it aims to focus more deeply into the emotional life of individuals, personal meanings and how people make sense of a particular phenomenon. Its methodology allows for creativity in data gathering and it encourages the capture of complexities, contradictions, similarities and differences with both description and interpretation employed in the analysis (Smith, Flowers and Larkin, 2009). The effect is to open up a range of nuanced understandings rather than finding similarities and reducing the data to derive a theory. Additionally, its commitment to the idiographic allows for the individual voice to be heard in verbatim extracts throughout the analysis. Finally, any generalisations or claims are developed cautiously and readers can make their own judgements regarding validity, plausibility and usefulness.

IPA is underpinned by three philosophical strands: phenomenology, hermeneutics and idiography. Phenomenology is the study of human experience and how we make sense of our embedded and embodied being-in-the-world, whilst also recognising that language, being socially-constructed, both constrains and enables linguistic description. Hermeneutics is principally involved in the interpretation of texts not only to uncover meaningful insights but also to reveal concealed meanings (Moran, 2000). In analysis, Ricoeur (1970) advocates using an empathic interpretation of the text, whilst also including a critical and questioning stance, a 'hermeneutics of suspicion' that can involve using other theoretical perspectives, such as psychoanalysis, to shed light on the phenomenon. Another double hermeneutic involved in IPA is the researcher making sense of the participant who is making sense of the phenomenon (Smith, Flowers and Larkin, 2009). The third strand of IPA is idiography which attends to individuals and focuses on a particular experiential phenomenon in a particular context. IPA is therefore an approach to qualitative enquiry that addresses the complexity of subjective phenomena both descriptively and interpretively. It uses a semi-structured interview process followed by a rigorous and systematic analysis; an accessible methodology with straight-forward guidelines (Smith, Flowers and Larkin, 2009) that is increasingly being utilised in psychology (e.g. Eatough and Smith, 2006) and psychotherapy (e.g. Mörtl and Von Wietersheim, 2008; Risq, 2011; Bourne, 2013).

### **3.4 Accessing out-of-awareness processes and generating metaphors**

Knowing that a traditional interview might only reveal the superficial I looked at professional techniques used to elicit unconscious processes. In 1955 Melanie Klein established her 'psychoanalytic play technique' whilst working with pre-verbal children (Klein, 1997), and Lowenfield (1979) similarly developed a 'sand-tray' method, so that through the building of a

physical world using miniature objects in a medium of wet and dry sand, unconscious processes can be communicated. Both these psychotherapeutic methods have been shown to be successful in accessing the intrapsychic worlds of children and adults. The objects used in these techniques are miniatures of everything that exists in the real world such as human figures, domestic and wild animals, trees, bushes, fences, transport and tools. Correspondingly, I devised a large 'object-tray' of 70 miniature objects to trigger subconscious processes and generate metaphors within my participants during the interview process. For guidance, I discussed my object-tray idea with a Jungian analyst who uses the sand-tray method in her practice, and I followed her additional suggestion to include extra objects such as mythical and ferocious beasts and a death-figure into my collection.

The belief that intrapsychic thoughts can be evoked by miniature objects has support from neuroscientific evidence indicating that "thought is made largely of images" (Damasio, 2006, p.106) and cognitive science demonstrating that "human thought processes are largely metaphorical" (Lakoff and Johnson, 1980, p.6). Therefore metaphors, constructed from our physical and social experience, seemingly structure not only our language, thoughts and actions, but are used particularly when we want to put across an idea from one domain into another (Lakoff and Johnson, 1980; Lakoff, 1987). Additional evidence from neuroscience suggests that image thinking and metaphor processing are both carried out in the right hemisphere of the brain (Schoore, 2003; Yang, 2012), the same hemisphere in which non-conscious socio-emotional information is processed (Schoore, 2003). This implies that imagery, metaphors and non-conscious socio-emotional processing are all closely connected in the brain.

As the challenges of phenomenological researchers include "how to help participants express their world as directly as possible; and how to explicate these dimensions such that the lived world – the life world - is revealed" (Finlay, 2011, p.19), I felt that my 'object-tray' would aid this process in the interview, as metaphors "draw attention to implicit aspects and may function as powerful starting points for new ways of seeing" (Alvesson, 2001, p.64). Thus I hoped that by using an object-tray and encouraging metaphor and imagery, some of these unarticulated or 'unthought known' thoughts and feelings (Bollas, 1987) could be brought into conscious awareness that could then be reflected upon by my participants.

### **3.5 Design**

I chose IPA as it is highly congruent with my philosophy as a practitioner and best suited my aims as a researcher. I wanted to understand what factors clients brought with them into therapy, how

they perceived their relationship with their therapist and how they made sense of their therapy. Unlike nomothetic approaches that focus on making general claims for a large population, IPA, being idiographic, requires a small, purposively-selected, homogenous sample so that convergences and divergences can be examined in detail. I therefore wanted a mixed-gender group of clients that had experienced a similar course of therapy; in order to reach these clients I needed help from their therapists so I chose one counselling agency in West London that offered self-referring clients up to 24 weeks of therapy. As it is standard practice in low-cost counselling agencies to have trainee practitioners, for homogeneity I selected only those practitioners who were on a doctoral counselling psychology course and in full supervision.

The reason I chose to use trainee practitioners rather than experienced therapists is that extant research has found considerable variations in effectiveness among experienced individual therapists working within one particular orientation (Luborsky, Singer, Woody et al., 1985) whilst also finding more variation in therapeutic effectiveness amongst trainees than amongst experienced therapists (Crits-Christoph, Baranackie, Kurcias et al., 1991). Overall indications are that some therapists work more effectively with some client groups while other therapists perform better with others (Cooper, 2008). Significantly in some comparison studies novice therapists were found to be more effective than experienced therapists suggesting that the way novice therapists work is more closely matched to that of trainers and supervisors; indications were that novices may also be more empathic and patient while experienced therapists may have become over-confident (Crits-Christoph and Mintz, 1991). A recent study corroborated these hypotheses for when clients had mild-medium severity and a good self-image, therapeutic outcome was better with trainee therapists (Dennhag, 2012). As this counselling agency only accepts clients with mild to medium severity, I thought that any weaknesses in trainee practitioner effectiveness might more easily be highlighted by their clients. Not only would this add richness to the data but any negativity of therapy reported by the ex-clients could then be fed back into the training.

As I was also looking at brief-term therapy I found, in the extant literature, that brief-term therapy has included durations from three hours (Ryan and Gizynski, 1971) to 52 weeks (Mann, 1973; Malan, 1976; Sifneos, 1976; Davanloo, 1978). Therefore I felt that anything up to 24 weeks met the criteria of brief-term therapy. I also wanted the duration of therapy to be comparable to the CBT service provided in the NHS: "Typically people with mild to moderate depression might receive between 6 and 10 sessions over 8 to 12 weeks. In cases of serious depression, up to 20 sessions of counselling are recommended" (IAPT, 2011). Interestingly, studies on dose-effect show that generally change is more rapid in the earlier stages of therapy, with 63% of clients showing significant improvement around 15 to 20 sessions, although those with complexities and characterological symptoms require longer therapy (Stulz, Lutz, Kopta et al., 2013). It would be

interesting to see if a similar outcome emerged from my study.

Whilst CBT therapists only focus on cognitions and behaviour, I wanted my participants to have experienced an integrative therapy as this humanistic-phenomenological approach works with 'psychological depth' and therefore has great interest in the processes occurring below the level of consciousness both intrapsychically and interpersonally.

### 3.5.1 Sampling strategy

Having obtained permission from the clinical head of the counselling agency to carry out my study with these practitioners and their ex-clients, I then contacted the doctoral student practitioners informing them of my research, asking for their participation and inviting any questions. I also suggested a meeting so that we could talk about the study. Although only two came to the brief meeting, all seven agreed to participate.

I put two sets of numbered Client Information sheets in each of the seven trainees' files at the agency. An attached covering letter asked them to pass my information sheet to their clients at the end of their final session. Attached to each sheet was a slip of paper for the client's name and contact number, and an envelope addressed to me. If the client was interested, they could write their details on the contact-slip, enclose it in the envelope provided and either give the envelope to reception at the agency or send it through the post. I would then contact them for further discussion and to arrange an interview. The date of the interview was not to exceed three months after their therapy ending date.

The criteria for client participation were that this was their first time in personal therapy; they had completed between 8 to 24 weeks of therapy; and they felt that they had undergone a course of therapy and ended a contract. The first 10 adult participants who self-selected through purposive sampling in the low-cost counselling agency would be invited for an interview. Each person who volunteered and whom I subsequently contacted by phone came to be interviewed.

After five months, as only two participants had volunteered, I widened my inclusion criteria on the Client Information sheet (Appendix 1 - modified version) to increase the duration of therapy range to 6 to 24 weeks and to include those who had had previous therapy. Originally, I had wanted naïve clients as I felt that they might bring more fearful and defensive processes into the therapeutic encounter than clients who had already experienced psychotherapy. This assumption was correct. Those with previous helpful therapy had more positive expectations of therapy and

were able to be more discriminating about the therapeutic process and the therapists' ways of being and working. I think that widening this criterion was a good choice as both naïve and experienced clients volunteered, and both brought a variety of aspects that contributed to the depth and richness of my study.

Additionally, I widened my criteria to include not just the doctoral trainees but all the integrative trainee practitioners working in the agency as each was on a similar post-graduate integrative counselling and psychotherapy training course. This potentially widened my access to more ex-client volunteers. Opening up the field helped, although it took over a year for 10 ex-clients to volunteer (7 female and 3 male). Interestingly, this ratio is also representative of the agency's client population. Participant ages ranged from 27 to 58 years, and 6 of these had experienced some previous therapy varying from 3 to 40 sessions.

All were white Europeans although they came from 5 different countries, and for 2 English was not their first language, although they spoke English well. 8 participants had a female therapist, 2 had a male therapist, and whilst one female therapist saw 3 client-participants, each of the other client-participants saw different therapists. Sessions varied between 8 and 24 (mean = 17.1). All client-participants had entered therapy with a range of psychological distress including suicidal ideation, complex bereavement, loss, relationship problems, alcohol problems, low self-esteem, as well as presenting with anxiety, stress and depression. My participants were the first 10 to volunteer and there was no discriminatory practice in participant selection or within the research.

### 3.5.2 Interview design

To help reduce anxiety about coming to an interview and to aid context-dependent memory (Godden and Baddeley, 1975) the interviews were carried out in the same building used for their therapy, and for some, although not intentionally, the same room was also used. This familiarity helped all but one, who had developed a negative transference towards the building due to personal issues with the location.

Before each interview I would set up my object-tray, grouping the items in a similar order (Appendix 2). I met and warmly welcomed my participants at the door of the building to make them feel at ease and build trust. Following ethical guidelines (British Psychological Society, 2010) at the start of each interview I reminded them about confidentiality, their right to withdraw at any time during the research process up until publication, and how I would protect their



anonymity. I told my participants that this research was for my doctorate, that it would be published as a thesis and that I would ask for their permission to include any quotes or segments from the interview. I stated the aim of my research and how the interview was to gather, in as much detail as possible, their experience of therapy and their thoughts and feelings around the therapeutic relationship. Two consent forms were then signed by both of us and each kept one copy (Appendix 2). I then introduced them to my object-tray (Appendix 3) on a table in front of them, and discussed how it was to stimulate thinking and that they were to use their 'gut-feeling' rather than their intellect when selecting objects.

Demographic details such as age, gender and ethnicity, plus reason for entering therapy, reason for ending, and whether they were satisfied with therapy, were the preliminary questions asked and recorded on a sheet (Appendix 4). I told them that sporadically, when they were speaking, I might make jottings on a pad, either about their object selection or as a reminder for me to return to something they had mentioned in their narrative, rather than interrupt them in their flow.

I used a loosely semi-structured interview schedule (Appendix 5) covering three main areas of focus: thoughts and feelings about therapy before starting, on first meeting their therapist and thirdly, perceptions of the therapeutic relationship as it progressed. In order to evoke their non-conscious processes I encouraged them to select objects from my object-tray, through an invitation such as: "Whilst thinking about this question have a look at the objects and see which of them you're instinctively drawn to. You can select one or, maybe, a few." I also prompted them at times with metaphor questions e.g.: "Can you think of an image that might describe what you've just said?" Additional prompts were used such as: "As you hold that [object], what does it signify to you?" "What was that feeling about?" "Can you say more?" In accordance with phenomenological philosophy, I was open and receptive whilst remaining aware of my own intrasubjective process and our intersubjectivity.

The interviews were audio-recorded and a short debriefing was carried out at the end of the session to ascertain how they felt about the interview process. All participants stated that they had enjoyed the interview process, felt that they had gained insight and understanding about their therapeutic experience, and additionally felt that the interview method had brought closure. Furthermore, they were offered additional therapy within the agency, albeit with a different therapist, should the need arise. Each interview lasted 1.5 hours.

### 3.5.3 Reflecting on the interview process

I had started a reflexive journal months before the interviewing process started and after each interview I noted my thoughts, feelings and impressions. In the earlier interviews, I noticed that I was particularly anxious as a novice research interviewer. With most participants there was an immediate and good rapport, although with one or two I sensed caution and distance. This translated into the interview process and there were times when I felt that the interview was veering completely off topic or that the participant wished not to engage with the objects. I had to bracket my rising anxiety and frustration and, with some unobtrusive grounding breaths, I was able to let go, be flexible, trust the process and sensitively work in my questions at appropriate times. Overall, I found that the shape of the interviews was circulatory as memories became stirred later in the interview that related to an earlier question or point, and this allowed us to return to that topic for deeper exploration.

Asking clients to reflect upon the therapeutic relationship was generally hard for most participants, as they had not previously considered their relationship with their therapist. The objects provided a very useful prompt and often their choice of objects both surprised them as well as offered them a different way to describe their thoughts. Some clients took to the object-tray readily whilst others were more reticent. There was also variability in the way participants were able to describe some of their experiences and, rather than being a passive interviewer, I was more active, especially in facilitating them to use metaphors.

IPA interviewing suggests that the interviewer is an “active co-participant” (Smith, Flowers and Larkin, 2009, p.64) and I used paraphrasing and reflecting back to encourage participants to add more depth and detail. Having transcribed two interviews I became worried that I was not interviewing in the right way, and that my prompting sounded too much like a therapist. I took these transcripts to my academic tutor, my research supervisor and my peers for their comments and was delighted to receive a positive response that I was working appropriately. I also continued to read books on interviewing to develop my skills (Ritchie and Lewis, 2003; Rubin and Rubin, 2005), and felt calmer when I read: “Interviewing as an art involves intuition, creativity, improvisation and breaking the rules. The interviewing techniques may be unconventional and novel. Techniques and standards of practice are used in a personal rather than standardized way” (Kvale, 1996, p.86). As I developed as an interviewer I began to relax and enjoy it, as well as really getting the sense of the co-constructed nature of knowledge.

#### 3.5.4 Ethical Considerations

Ethical approval was given by the Research Ethics Committees of Metanoia Institute and Middlesex University (Appendix 6). Participants were told both orally and in writing throughout the process that they could withdraw from the research at any time and for any reason. On the consent form I requested that notice of withdrawal be given by letter or email and that, if they withdrew, they could decide what happened with the data they had provided. I also allowed them the choice of declining to answer questions in the interview, with a caveat that, if they declined to answer too many questions, it could lead to termination of their participation. On the information sheet I mentioned that as a memory aid they would be asked to select objects from a collection of items that would be a focus for discussion. If they were interested in taking part in my research and had passed on their contact details to me, I would then contact them for further discussion about the research. If they agreed to be interviewed we would then arrange a convenient time for this to take place, and all the interviews were conducted in the same building wherein they had their therapy. As this building is staffed both during the day and evening it was a safe place to carry out interviews with low risk or hazard.

On my interview schedule I made notes that reminded me to state, at the beginning of the interview, anonymity protection, what the research would be used for, their right of withdrawal at any time and what the research was about. I mentioned that the interview would be rather like a one-sided conversation, much like in therapy, and that some of the questions that I would ask might seem self-evident or repetitive as I was trying to get a nuanced understanding of their experience that would add more depth and texture to the data. I invited them to feel free to take their time in thinking and talking about the questions. I also reminded them that part of the interview process would be to select objects from the tray that they were drawn to through their gut feeling rather than their intellect. At all times during the process I behaved in a respectful, friendly and supportive manner, going at their pace whilst also containing the process by observing the time and allowing for a short debrief discussion at the end.

To ensure confidentiality all audio-files were kept on two thumb-drives and locked away, whilst paper forms were kept separate in other secure filing-drawers. Transcripts and analyses were filed on a secure computer. Anonymity was protected by changing names, places and any identifying features on the transcripts so that there could be no cross-matching with the paper forms.

As a phenomenological researcher I hold an ethical responsibility to be: open, respectful, humble, sensitive, flexible, curious, empathic, compassionate and accepting that what participants tell me is their truth or the truth that they wish to present to me (Finlay, 2011). Recognising the power that I had as a researcher, I took care when analysing and in the writing-up to observe respectfully each person's account, valuing their candid contribution. I did not include anything too personal or that might embarrass.

After transcribing each audio-recording, then reading and checking it against the audio recording a few times for accuracy, I sent the transcript to the participant for their approval, comment or deletion. One did not reply and another asked me to exclude some highly personal material. Otherwise all gave their validation and consent. I repeated this communication process again after I had established the themes and illustrative quotes and sent each participant my selection of their extracts. In this way I kept them informed of the process and progress of my analysis and also gained their approval and continuing consent.

### *Power*

I wanted the research experience to be creative and empowering for my participants and I recognised this to be a negotiated process. Although the power balance was asymmetrical, as I was in control of the interview, subsequent analysis and write-up, by involving my participants throughout the process gave them a measure of control. By giving participants full information I was therefore adhering to the guidelines of fidelity, autonomy, beneficence, non-maleficence, justice and self-respect (British Association for Counselling and Psychotherapy, 2013).

During the interviews there were moments when painful memories were evoked and some felt distressed. I contained the moment until they indicated that they were ready to continue, finding that they were able to manage themselves and their emotional process. In most interviews I felt that we connected well, and they all reported to me in the de-briefing that they had enjoyed the process, that using objects had been interesting and, for some, fun. Moreover, they all felt that it had brought closure to their experience.

If, at the end of the interview, they had felt distressed and needed help I would have stayed with them and discussed whether they would then like further therapy. It would then have been possible for them to arrange for another referral assessment through the receptionist present in the building.

### 3.6 Method of analysis

Predominantly the focus of IPA analysis is on how participants make sense of their experience and how the researcher interprets their understandings within theoretical frameworks. The analytic process in IPA is characterized as an iterative and inductive cycle that moves continuously between the individual and the whole, the particular and the shared, as well as from the descriptive to the interpretative and from the participants' perspectives to a psychological perspective. IPA uses a rigorous systematic analysis with guidelines that have been presented as steps suggested by Smith and colleagues (2009):

#### *Engaging and immersing myself in the data*

Having transcribed the audio-recording after each interview, I listened to the recording a few times whilst reading the transcript, correcting any errors and adding any missing linguistic expressions and pauses etc. Each interview was then read many times and during this process, as I was familiarising myself with each account, I started to divide the transcripts into meaningful chunks of sentences. Originally I tried using the computer software Atlas-ti5 to code and analyse, but finding it confusing and preferring to see the data displayed as a whole, I switched to using spreadsheets. Each transcript was then entered into Microsoft Excel and each chunk of data was sequentially numbered by giving it a different line in Excel. Each chunk of data encapsulated a whole thought or an idea but much later, after discussions with my supervisor and peers, I decided to refine and reduce my chunks into smaller units of interest, in case depth was lost by having these larger chunks. I re-coded and re-numbered all the transcripts and, in effect, started the whole coding process again. Although frustrating and time-consuming the process deepened my immersion into the data and I found I was drifting off to sleep and awakening with verbatim extracts from my participants running through my mind.

Remembering how we were together in the interview, I coded and analysed the data to reach a deeper and more detailed reading of the text, and coding was done in three ways: descriptively, linguistically and conceptually. All coding comments were noted in the left hand column next to the data on the spreadsheet. In order to discriminate between these coding comments, I used a normal typeface for 'descriptives' and selected key words, phrases and explanations that had a phenomenological focus explicitly used by the participant, with comments on why they mattered; I used italics for 'linguistics' and this comprised the para-verbal and verbal expressions, laughter, repetitions etc.; and finally I used underlining for the 'conceptual comments' of deeper

interpretations that related to psychotherapy theories. In the column to the right of the transcript I listed the objects chosen and highlighted these in red. To the right of this object column I wrote 'in-vivo' quotes or emergent codes. Columns to the right of this I used for themes (Appendices 7 and 8).

Each of the transcripts was coded separately, and gradually as I worked my way through them I was getting a feel about the data across all participants. This was a long and laborious inductive and iterative task that required moving back and forth within and across transcripts. During this process I reviewed and added additional comments as, having coded all ten transcripts, my mind was steeped in thoughts about emergent themes. The data also became more complicated and unwieldy as I tried to include the selected objects chosen from my object-tray into my conceptual thinking to see if I could find a different perspective. For peer validity checks, I also sent some colleagues transcripts to see whether their analyses matched my thinking and whether they added any additional insights.

#### *Developing emergent themes*

"Emergent themes should feel like they have captured and reflect an understanding" (Smith, Flowers and Larkin, 2009, p.92) In this process I distilled the emergent themes into pithy phrases of psychological understanding. It was important that they were grounded in the particularity of the text and yet with enough abstraction to be conceptual, so it involved holding the knowledge that I had assimilated while identifying similarities, differences and nuances across all transcripts. This whole inductive and interpretative process became a dynamic hermeneutic circle whereby the part influenced the whole and correspondingly the whole influenced the part. Again, this was a long, laborious task and I started feeling lonely and isolated, doubting my ability. It was going so slowly that I developed negative feelings towards the whole study and felt reluctant to continue. Talking about my negativity to colleagues helped me to overcome this hurdle. I also took transcripts and themes to peers and IPA groups for validation and to gain additional perspectives that then became integrated into the data. For example, I would type verbatim extracts from each of the transcripts that I thought related to a particular theme onto sheets of A4 paper and, without revealing my themes, I asked either individuals or the small groups (if this was an IPA meeting) to have a look at the data and come up with their own themes based on the typed extracts (Appendix 11). We then discussed their thinking and whether their thematic ideas about the data matched the theme titles that I had already developed. In this way, I gathered knowledge from my peers, many of whom were clinical practitioners or trainees, and this provided a peer validity check that added transparency, coherence and rigour to my analysis. Eventually I arrived at 89 emergent themes (Appendix 9).

### *Searching for connections across emergent themes and developing superordinate themes*

Printing out a list of the 89 themes, I cut them up individually and spread them out on a table, and categorised these into 7 clusters of similar understandings or in opposition (Appendix 10). I used my reflexive diary to think about my codes and clusters, and their operational definitions (Saldana, 2009) to get an overview of how they related to each other in these categories, and work out a hierarchical structure. Using mind-maps and diagrams, each cluster was gradually reduced further through the processes of abstraction (i.e. developing a higher order label) and subsumption (i.e. where an emergent theme or in-vivo quote describes how the cluster relates). Although I had my first superordinate theme with nested themes, for months afterwards, I grappled with the meaning of the other theme labels and whether they best captured the concepts and meanings within the data-sets. Clustering and theme-labelling were again discussed with both peer groups and my supervisor and finally I identified 3 superordinate themes (Appendix 12).

As I reflected on my ambivalence throughout this process of analysis I realised that I had overcomplicated much of the process trying to find a different way of describing my participants' processes instead of staying with their descriptions. For example one superordinate theme title, 'Forming layers of emotional connection' was simplified to 'Feeling safe and understood'. That reflection gave me renewed energy, excitement and interest, and feeling contented with my codings and labels I felt ready to move on. I also wondered if, when I was interpreting their transcripts, a parallel process of fear had been operating between my participants' accounts and me.

Each participant's transcript in Excel was separated into the 3 superordinate themes so that I could move between theme and participant either individually or within a group. This process of re-coding and continual updating within and across transcripts took several months and gradually my understanding deepened and the data began to take shape. Importantly, I did not just choose themes for prevalence across the data-sets, but also for divergences and ambiguities. Finally I felt satisfied that the superordinate and related themes had become woven together in a coherent way that described the connections, patterns and flows of how individuals experienced their therapy.

After checking these with my supervisor, I selected extracts and examples from my data-sets that I thought captured the themes most vividly. Following this, I sent each participant a list of my themes with the extracts that I wished to use from their transcript for their approval and consent. Each participant (bar the one who had given full consent but not wished to communicate further) received only their own extracts. They all responded quickly, affirming their interest and consent.

A master table of themes linking participants' numbered extracts was produced in Excel (Appendix 13) followed by the construction of tables with the selected quotes for each theme (Appendix 14). Finally, for a quick reference, I produced a table of the selected quotes used in my analysis to complete the audit trail (Appendix 15).

### *Writing-up*

Having sent the first draft of my first theme to my supervisor for comment, her reply suggested that by using so many quotations my analysis lacked clarity; its detail was overwhelming. To reduce description, develop more complexity and reach a deeper level of interpretation in my writing, I found I had to omit or reduce participants' extracts. This was a difficult tussle for me, as having been given such rich descriptions I felt that by distilling their accounts even further I was letting my participants down, especially when I had wanted to present their 'voices'. I was also trying to include their object choices in the main body of the analysis, which further complicated the account, but finally, after discussion with my supervisor, I let this go and decided to treat the objects and their symbolism separately in the discussion section. Both these decisions tightened up the writing, and gave it more depth, complexity, coherence and flow.

Not feeling that I was a natural writer with a compulsive urge to write, I set a goal for myself to write between 300-500 words every day. Often I had to force myself to start writing and surprisingly, I frequently found that I completely lost sense of time, was in the flow and enjoyed the process of weaving the participants' voices with my interpretations.

The hermeneutic circle was also evident throughout the writing process as, during this reviewing and refining process, other problems surfaced. I found that in my second superordinate theme two themes overlapped, and I had to be very specific in choosing extracts that particularly emphasised the differences. I also discarded a superfluous fourth theme at the end of the third superordinate theme, as, although interesting, it added nothing substantial to what had already been written.

Observing the idiographic element of IPA, my analysis was written as a case within theme presentation by illustrating how each superordinate theme applied to each participant so that the reader could gain a sense of the individual's whole experience. Each participant therefore had a voice, although some participants had richer and more illuminating extracts for some particular themes while others were richer in other themes.

After this section was over I felt absolutely drained, without a thought left in my head, and sent it



to my supervisor for feedback. The whole process of writing had seemed to have taken over my life and during this time I thought of little other than my research. There were moments of flow and excitement but mostly it took resolve and determination to keep going. It was hard mental work and during those times when I vacillated on whether I was cut out to be a researcher, my overriding thought was that I would let down my participants by not finishing my project and allowing their voices to be heard. I felt that it was important research and needed to be done.

Writing the discussion section and re-writing some of the methodology was also a slow process. Every time I wrote I would have to look for previous evidence in the literature and sometimes all I could do was to read a few research papers that day with no available time left to write. I set myself a time-line to finish and had to extend this time and again. There were times when I felt dejected as I was hardly progressing; I also felt that I was not really offering anything new but only confirming and complementing previous research. Feeling stressed with palpitations, I spoke with my supervisor whose calmness and encouragement normalised things for me; she outlined a possible structure to my discussion based on the questions I had asked, and her support helped to reduce my anxieties.

It took some time to realise that my study was offering a detailed exposure of the fears that participants experienced at the beginning and throughout therapy and the processes involved in overcoming them. I also became aware that in using my object-tray I was using an innovative methodological tool to facilitate meaning-making and communication as opposed to just using discourse and verbal communication in the interview process. I also found that in the writing of my discussion my findings challenged some previous research such as whether it was ultimately the client or the therapist who had responsibility for successful outcome, client attachment styles and therapeutic bonds, deference, participant truthfulness and objections about interviewing clients.

### **3.7 Trustworthiness and Rigour**

I followed the guidelines put forward by Lucy Yardley (2008):

#### *Sensitivity to context*

I was sensitive to context as I situated my study in the relevant theoretical and empirical literature. Although at times it was re-discovering what was already known, it complemented and expanded previous knowledge by offering rich, varied and detailed descriptions of clients' actual

experiences. My study provided empirical data from a homogenous sample that described how client-participants made sense of the psychotherapy offered in the same counselling agency, with all participating practitioners being trained in the integrative approach.

In the interview process I endeavoured to put my participants at their ease, was empathic and negotiated any interpersonal difficulties. Throughout the whole research process I was respectful of both sets of participants' involvement and treated all the data sensitively. All analytic interpretations are grounded in the presented verbatim extracts, and findings are linked to relevant literature in the discussion.

### *Commitment and rigour*

"[Q]ualitative research is constantly evolving, and it is important for qualitative researchers to be able to be flexible and creative in the way they carry out their research" (Yardley, 2009, p.239). My object-tray was based on a sound psychoanalytic technique and provided a creative method for prompting and eliciting a deeper understanding of the processes experienced in psychotherapy. Metaphors encouraged authentic and imaginative descriptions that helped convey implicit meaning in an easier way (Alvesson, 2001).

The IPA methodology was congruent with Counselling Psychology philosophy as well as the integrative epistemological theories and practice of psychotherapy and best matched the exploratory nature of my research question and the way I conceptualised the subject matter. My analysis was conducted in a systematic fashion and contained not only breadth and depth, but also, in presenting negative data, rigour was increased (Patton, 2002). I observed the idiographic element that allowed for continuity and revealed particularities of each individual as well as their similarities.

I have also kept my participants informed of the process throughout for consent or withdrawal.

### *Coherence and transparency*

There is a paper trail of all stages of the research including interview schedule, full transcripts and analysis. All analyses are on spreadsheets on a Master Table in Excel that can be cross-referenced within and between cases. I have a reflexive diary containing my reflections, ideas, notes, diagrams and thought processes made in the course of the research. I have given examples in the methodology section of the decisions made during the research process. In my analysis and discussion I have used reflexivity to "try to make explicit the ways in which

intersubjective elements impact on data collection and analysis” (Finlay, 2011, p.105) thereby demonstrating how my subjectivity had an influence on the research process. I have also used peers, IPA groups, tutors and my research supervisor for discussion, review and validation at various points throughout the research process.

## **4..Findings**

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This section analyses the interviewees’ narrative accounts that have been organised into three superordinate themes with nested themes. In participants’ accounts I looked for lived experience with textured, nuanced and metaphorical descriptions of the existential themes of embodiedness, spatiality, temporality, and relationality (Van Manen, 1990). My interpretation of implicit meanings draws on psychodynamic ideas of transference, projection and counter-transference (Racker, 1968) as well as from theories on intersubjective/interpersonal relating (Stolorow and Atwood, 1992; Beebe and Lachmann, 2002; Schore, 2003; Hycner and Jacobs, 2009) and reflexivity (Finlay, 2011).

I present my interviewees’ evidence within their individual contexts so that the reader can “follow the story of each person through the analysis” (Smith, Flowers and Larkin, 2009, p.110) in a case within theme presentation. In my selection, frequency was not the only criteria, I also chose the surprising and contradictory wishing “to capture the layers of complexity” (Finlay, 2011, p.18) and to demonstrate the range of convergence and divergence that emerged from the transcripts. Although the themes are differentiated they interlink with some overlap across and between.

Table 1 (below) presents an overview of the superordinate and related themes showing which transcripts the themes came from.

Table 1. Superordinate themes and themes linked with interviewees' experiences

Superordinate themes	Themes	Evidence		No Evidence		
<b>1. Therapy as dangerous</b> Fears brought into therapy	1.1 Going into the jaws of the unknown	Tess Lisa Mike	Dani Kira	Pat Tom Roza	Ed Jane	
	1.2 Dropping the mask that we wear	Tom Dani Jane	Roza Kira Mike	Pat Tess	Ed Lisa	
	1.3 It's the slippery slope	Jane Lisa Mike	Kira Tess	Pat Roza Dani	Ed Tom	
	1.4 Depth-gauging for undersea jagged rocks	Tess Lisa Jane Roza	Tom Dani Kira Mike	Pat	Ed	
		<b>Positive</b>		<b>Ambivalent</b>		<b>Negative</b>
<b>2. Feeling safe and understood</b> The early developing therapeutic relationship	2.1 Feeling loved	Pat Lisa Tom	Roza Dani Kira	Mike Tess		Ed Jane
	2.2 Building trust together	Lisa Pat Tom Ed	Roza Dani Tess Mike	Kira Jane		
	2.3 Feeling heard and understood	Lisa Roza Pat Kira	Dani Tom Mike Tess	Jane		Ed
	2.4 Overcoming fear and risking self-exposure & vulnerability	Kira Lisa Roza	Pat Dani Tom	Ed Mike Tess		Jane
		<b>Positive</b>		<b>Ambivalent</b>		<b>Negative</b>
<b>3. Journeying together for personal discovery and change</b> Working collaboratively towards achieving aims	3.1 Showing me the way to go	Dani Lisa Kira	Roza Tom Pat	Tess Ed		Mike Jane
	3.2 Setting everything whirring and thinking	Dani Lisa Kira Ed Mike	Roza Tom Pat Tess	Jane		
	3.3 Becoming myself	All ten interviewees				

## 4.1 Analysis of Themes

Transcript notation used in extracts:

... a significant pause in the narrative  
[...] non-relevant material omitted

### Superordinate Theme 1: Therapy as dangerous

All participants had expectations that therapy would be beneficial, but eight participants also expressed fears of there being an element of danger about therapy and that engagement in the therapeutic process may put them at risk of harm in some way. They were anxious as to what was expected of them. Loss of personal control, vulnerability, deterioration, fears of discovery and the unknowingness of how the therapeutic process would affect them were the major fears that emerged. Whilst five participants found their fears abating after a few sessions, for three others this was not the case and their fears continued throughout. Interestingly, Pat and Ed, having had good experiences with previous therapy, did not report any fears.

#### 1.1 *Going into the jaws of the unknown*

Clients experienced fears of therapist inexperience, therapeutic efficacy, and the giving up of personal autonomy, uncertain whether and how they were going to be changed by the process of therapy.

Tess, who had not had previous therapy, hesitantly picked up a little girl figure from the object-tray to describe the moment when she discovered that her therapist was a ‘*young*’ trainee practitioner. It generated doubt about therapy as she feared her therapist’s inexperience:

*‘..without the range of experience of having helped erm. . .sufficient range of people to be able to help me.’*

Likewise Dani became apprehensive after the first contact with her therapist and felt awkward in telling me that initially she did not like her. Protecting both herself and her therapist by avoiding a characterisation of her therapist, Dani switched to using a dangerous journey metaphor to conceptualise her fear of uncertainty of whether and how she was going to be changed by entering a process that might have irreversible effects:

*‘When I first met her and. . . (selects alligator with an open jaw). . .I suppose it was going into the jaws of, you know, the unknown. I was going into very murky waters. And I*

*didn't know what. . .I didn't know how it would work[...] whether I would come out the other end alive[...] whether I would come out the other end the person that I was[...] it's a bit like swimming down the Amazon[...] it was the significance of the therapy and how I would be able to navigate.'*

Lisa also imagined the combination of therapy and the therapist to be a powerful unit that would produce irrevocable change. There was an element of luck and danger involved in the process and the wrong combination of therapist personality and skill could damage her: *'You don't even know where all this is going[...] he could eat me alive if he wants.'* Experiencing suicidal ideation she therefore had to balance her fears about her life situation with her positive thoughts about therapy alongside her fears about putting herself through an unpredictable process. Selecting an axe Lisa described her thoughts of therapy:

*'...when you cut something it's either good or bad. I mean it's going to do something[...] it's going to be broken. It will never be like before. Something. It will have a consequence.'*

Describing herself as a private, defensive person Kira feared acknowledging the truth about her life and having to take responsibility. Not only was she aware that she would have to alter her avoidant behavioural pattern and talk about her issues, but the unpredictability of what kinds of changes might take place in her psyche during the therapeutic process felt terrifying. Kira's description of therapy was of herself emerging and changed in form in a significant way; and invoked in me an image of a chrysalis-containing pupa or an incubated egg whereby the emergent form is unknown:

*'I think I was frightened and I feared what I would feel as I came out of it[...] I knew that when I came out of it I was going to be a different person. . . but I. . .I didn't know what course of action I was going to take or who I would become or would it change me as a person or would it change my thoughts towards my family.'*

## *1.2 Dropping the mask that we wear*

This theme encompassed a range of fears relating to psychological exposure when hidden aspects of self become figural and the person is seen without their social mask. The fears included identity loss, vulnerability, humiliation and shame, as well as fears of what might be discovered in the process of delving into the past.

Tom feared therapy as it was an admission that he needed help and could no longer manage his distress on his own. The act of coming to therapy therefore exposed Tom's sense of failure and challenged his social-conditioning beliefs of masculinity: *'to actually ask for help goes quite deep'*. He had been conditioned to help others and that to ask for help means: *'you're not carrying the load. You're asking someone else to carry it.'*

Coming to terms with maternal bereavement and divorce, Tom felt vulnerable and feared that therapy could potentially invite being wounded again, and he projected a similar anxiety about participating in the interview with me; that I too may hurt him if he shared too much of himself in the process. Whilst talking, Tom selected from the object-tray, the heart, arrow and the wheel-chair, in which a figure in bandages is seated. In having therapy Tom possibly felt emasculated, invalid, weak and worthless and, perhaps, feared female power:

*'I was anxious because I was about to open up to somebody I didn't know erm. . .for all I know, you could be an enemy, and I could be showing you the map of my heart.'*

In a similar fashion, Roza had also learned to keep all feelings hidden and therefore to discuss emotions with another challenged her cultural upbringing. She too voiced fears of becoming vulnerable in therapy and more importantly she feared being shamed by the exposure:

*'In the beginning. . .I was like terrified. I was thinking, my God, because you will show your weaknesses and everything and it's embarrassing[...] I was leaking my secrets.'*

Roza associated this emotion with a childhood trust exercise whereby she was unable to fall backwards into another's arms. This fear was projected onto her therapist who she thought might not be able to hold and contain the weight of her material and, furthermore, might be unable to catch her when she was falling/dying in shame. This being the first time she was disclosing her 'secrets' to another, she feared becoming psychologically hurt in a terrifying and humiliating process:

*'So it was a bit of a terrifying thing[...] the fear of not being caught [sic] by somebody.'*

Many clients feared betraying family and friends:

Kira: *'I don't like to talk badly about people[...] and especially not my family or my staff.'*

Kira was in a double-bind, with or without therapy she was fearful of self-disintegration. Years of emotional suppression was self-alienating 'making me crazy' but the process of discovery and its consequences was also terrifying:

*'..the fear of. . .admitting major things was scary to me[...] and all those things that I knew I had to bring back up again. . .that I managed to suppress for so many years. . .but they were bubbling. . .aggressively inside of me and I knew that it was all going to just come to a break-down mode and. . .it. . .it had to be done 'cause it was making me crazy like I was turning into a strange person[...] the discovery path was terrifying and I could see it and I knew it and[...] I didn't know what was going to happen[...] and it was scary.'*

Jane too held fears of discovery and disloyalty, which were apparent in her discomfort and reluctance to 'delve' into family relationships in her therapy: *'I didn't want to talk about them.'* Challenge to Jane's well-established mental constructs of her family by her therapist affected her considerably and played a key role in her decision to terminate therapy.

*'Suggestions are good but when they make me quiz it's like, that, for me, didn't help.'*

Similarly, Mike's fears of discovery when discussing his parents went alongside fears of exposing his vulnerability. Feeling *'uncomfortable'* whenever the subject of family relationships was introduced, Mike dealt with his underlying anxieties by dissociation, imagining a cartoon version of therapy wherein he could observe himself rather than engage in a truthful and emotional exploration.

*'...when we had that type of conversation it was like cartoon therapy thing and I was like. . .sort of. . .like a cliché of going to see an analyst.'*

### 1.3 *It's the slippery slope*

This theme relates to the fear of decline, that instead of improved well-being, therapy would cause mental, physical, relational and financial deterioration.

Jane's mounting anxiety and confusion after a relationship break-up triggered not only a recurrent fear that her mental state was symptomatic of mental illness, but that it might finally be diagnosed in therapy:

*'it's the slippery slope sort of thing[...] I suppose I think if this was an ambulance (picks up army/red cross truck) I suppose I was thinking that I was going to be going mad like some. . .I'm going to end up in a mental institution 'cause I'm going off the rails. I was terrified of that basically.'*

She perceived having therapy as a weakness: *'if I come here, it means I have a problem'* and increasingly she found it difficult to attend sessions because of her intensifying mental confusion:

*'when I used to leave I used to be questioning, questioning, questioning, questioning the whole thing[...] And actually made me feel. . .sometimes made me feel worse.'*

Not believing that therapy was helping her, and furthermore that it was a financial drain, Jane rationalised her decision to end therapy: *'the benefits weren't outweighing the costs.'*

Alarmed by the state of her mental health, Kira also found it difficult to trust therapy: *'I was very defensive. I didn't. . .I was. . .didn't want to have that breakdown.'* Like Jane, there were also times when Kira left therapy sessions scared and confused about what was happening to her, feeling lost:

*'And scarily for myself where I would sit at the bus-stop and I would be thinking, I don't know. I don't even know what bus I need to get on.'*

Lisa too feared that it might deplete her of her resources:

*'cause you're giving so much[...] I needed it to be good, to end up good otherwise it's a waste of time. Waste of energy. Waste of my sanity[...] it could have. . .could have ruined my. . .my brain.'*



Continuing with this theme of injury Lisa utilised an accident metaphor:

*'Either you will be really lucky and you will have nothing or you will get everything broken and then you have to deal with that afterwards.'*

Tess chose a bandaged figure in a wheelchair to depict herself, worried that her physical body would further deteriorate if she could not calm her anxiety and reduce her tension. Not wishing to continue with her prescribed medication, Tess wanted to find the root cause of her anxiety and like Jane, finance was another concern particularly as there is no predictable outcome with therapy. Mike too was doubtful about the efficacy of therapy in general and harboured implicit fears of dependency by becoming trapped in a never-ending process. He questioned: *'would I still be coming in five years time and talking about the same thing?'*

#### 1.4 Depth-gauging for undersea jagged rocks

This theme depicts the fear of positioning self with other. Negative transferences emerged with regard to meeting, connecting with and talking intimately to a stranger.

Tom worried about rapport, good-fit and acceptance in meeting someone new:

*'You don't know whether the person you're going to get on with or not, is going to understand you or not, whether they're going to tolerate you or not.'*

Whilst Tom realised that, as he was adjusting to his therapist, so his therapist was also adjusting to him, he nevertheless felt vulnerable, like a lamb amongst wolves:

*'for the first few sessions it was really potentially dancing amongst wolves because I didn't know. . .I had no idea what the person was.'*

Feeling unequal, he used a scuba-diving metaphor to describe the process of positioning himself with his therapist to prevent getting hurt: *'it's like depth-gauging[...] it is actually finding out where the. . .you know, the undersea, jagged rocks are.'* In addition Tom feared the possibility of having to mould himself to fit the therapist's approach: *'I would have to fit into some medical model or some psychological model or social model of interaction.'*

Lisa remembered how startled and confused she felt on meeting her male therapist for the first time as it had triggered negative transferences from her past and current relational patterns with men. She reached for the crocodile and the tank on the object-tray to depict her consternation:

*'It represents the man and just the dangerousness about it that I had. . .like really negative feelings. Being scared[...] kind of a. . .OK the war is there[...] this is the enemy.'*

Dani's first contact with her therapist was on the phone; a conversation which left Dani holding negative feelings about her therapist's relating style and doubtful of a successful therapy. Picking

up the padlock she described her anxiety:

*'Well, I suppose I was the lock and she was the key and I didn't know whether she'd have the right key to open the lock.'*

Dani's hesitancy at this point in our interview demonstrated her reluctance to tell me that her therapist lacked warmth and friendliness. It was easier to tell me what her therapist was not rather than how Dani actually perceived her to be: *'She wasn't a soft pussy-cat'*; and also easier for Dani to compare my approach with her therapist's:

*'on meeting you, you were very smiley and you made me feel very much at ease and I, I had no idea what the. . .this was going to entail but I knew that it was part of a research so. . .but I felt totally at ease. When I met her, I just sort of thought she's not. . .she wasn't as friendly and as open and as. . .and I didn't feel relaxed within her company.'*

Describing herself as feeling *'a bit scared'* and *'apprehensive'* of her therapist's *'stand-offish'* persona, Dani selected a policeman from the object-tray to demonstrate her disempowered position in relation to her therapist: *'she was more of the authoritative figure[...] I was the putty in her hands.'*

Jane became increasingly disturbed by her therapist's somewhat silent manner and a negative transference of suspicion was generated that remained with her throughout her therapy:

*'I was always thinking what does she think of me? What does she actually think of me? And I was often thinking that. Erm. . .and, you know, I really wanted to say: What do you really think? Do you think I'm crazy? What do you really think of me?'*

Kira struggled with ambivalence, liking her therapist one week and then mentally dismissing her another week: *'Ah, I don't think she's offering me really very much. I'm not sure she's actually very good.'* She also restricted eye-contact with her therapist to prevent intimacy and emotional breakdown:

*'I knew I was doing it right from the start but I was so scared about breaking down and crying and all that, that I just sat there like. . .and. . .and I can remember clearly like. . .almost. . .gaze. . .like gazing out because I didn't want to be really interacting. I didn't wanna look, you know, at the counsellor in the eye, in case, you know, she gave me a look, or a sad look that might make me upset. I would gaze out of the window or I would look around the room or I would, you know, get. . .sit. . .move around my chair.'*

Whilst talking and looking at the objects, Kira instinctively picked up the black cat:

*'I don't know why I'm drawn to it but I feel like it's almost like a. . .a. . .something of the night. . .sneaky, like. . .a little, you know, like. . .when you think of a black. . .a dark, black night and you see a little cat sneaking along. Like, I feel like that was me. . .in the meetings. Like I was very sneaky in the way I controlled the situation.'*

Roza told me how she closely monitored her therapist to assess that whatever she *'threw'* at her, her therapist would not *'freak-out'* or *'sag'* under the weight of her *'weird things'*. Fearing shame

when disclosing negative aspects of herself, Roza tried to protect both herself and her therapist:

*'I think there was my protection for me too. I'm not going to, you know, throw something important for me and then she just freak out. Or I don't know, or just, be surprised or. . .and also I need to. . .I was getting ready for myself to, you know, show my weaknesses which is not nice to show them. Erm. . . it's a. . .it's sometimes humiliating.'*

## Superordinate Theme 2: Feeling safe and understood

This superordinate theme illustrates the dynamic emotional processes that evolve between client and therapist, and that for optimal outcome these processes need to continue to operate between therapist and client throughout therapy. Interviewees communicated that feelings of safety, trust and being heard and understood were the necessary components enabling them to relax, overcome fears and talk intimately about themselves and their difficulties. The way these interacting constituent processes developed varied for the different interviewees, and interestingly for Tess, Mike, Ed and Jane the three processes did not develop sufficiently well and they reported disappointment. I wondered whether the different emphases that all ten interviewees gave to each theme indicated their own unconscious needs and wants, as during our interviews some of those same desires became apparent in the co-created process between us, consciously articulated and also in my countertransferences.

Importantly there are many indications that, once interviewees could place their therapist into a positive schema, a deeper therapeutic relationship evolved. Although the first three themes interlink and overlap they are reported by the interviewees as different processes. Feelings of being suffused with warmth, being held and attended-to feature strongly in the 'feeling loved' theme, suggesting that the client is an active receiver whilst in the next two themes a more dynamic relationship of shared activity is described. Ultimately, when clients experienced all three interacting emotional processes and felt deeply connected to their therapists, this gave them the security to open up.

### 2.1 *Feeling loved*

Most interviewees felt a strong, warm connection with their therapist that developed early within their therapeutic relationship, while for Ed and Jane this connection failed to happen. The sense of warmth, love and attention was described by Pat, Roza, Lisa and Dani in terms of a maternal love, or for Tom an erotic and spiritual love, that provided safety and support, and enabled

exploration, play, disclosure and emotional expression.

Pat, maternally bereaved, was missing her mother and this need materialised in the way she described her therapeutic relationship. Selecting a heart and coloured marbles from the object-tray, she depicted her relationship with her gentle and soft therapist as: *'safe and beautiful in the sense of a really good human relationship.'* She described it in terms of *'a shallow river with very clear. . .warm, soft water'* wherein she could safely paddle, and conceptualised her therapist as: *'the river and the sunshine'* with herself as: *'happy in a childlike way. . .no cares and lots of possibilities.'* These metaphors suggest a happy, well-attended child-self playing in a warm, sunny, safe and transparent environment, feeling loved and secure.

Roza's chosen object to depict her very friendly, bright, warm, straight-forward therapist was the sunflower: *'my kind of sunny time in the week.'* Roza felt secure, luxuriating in the knowledge that that hour of 'sun' was just for her. Feeling relaxed, *'free'* and *'wasn't afraid to express myself'*. Roza felt *'safe and good in her company'*. She also felt connected and cared-for when her therapist passed her tissues when she cried: *'It's nice sometimes to do something with somebody not just alone. So it felt good.'* Again, there is a sense here of an attentive mother watching her infant play, drying her tears and warmly attending to her in an intimate way. Roza conceptualised her therapy as a developing, caring relationship and a journey undertaken together, hand-in-hand:

*'In the beginning she probably just watched me just running around. Later she took my hand and walked somewhere more with me.'*

Lisa, who held negative transferences towards men, was very surprised to find how rapidly she felt safe with her male therapist. She felt *'lucky'* in being given this male therapist whose humanity, empathic interest and professionalism increased her positive expectations within a few sessions: *'Oh it felt really good.'* Lisa depicted him as a protective *'safety-net'* and associated him with her mother who, when she fell, would gently help Lisa up again:

*'I would say the best example with my mum. That whatever I do she's there. She won't judge me bad. You know she would do the same. She will try to catch me and you know, help me to get up again. Not take me and put me up. Like just help me to do it. And it was that same feeling. . .somehow. So that was nice coming from a guy.'*

Lisa spoke of him with such tenderness and love during our interview that I was aware that she had developed a deep affection for him.

Dani, having initially experienced her therapist as unfriendly and stand-offish, began to relax and like her after three sessions. Feeling less like an object, she selected a piece of soft material to describe their new relationship:

*'It was softer. . .I suppose it was more comforting. It didn't feel as if I was being scrutinised as much. It felt a bit more comforting and relaxing.'*

Not only did the soft felt remind Dani of being a child: *'that's what my daughter likes when she wants comfort, she wants 'blanky''* but Dani particularly appreciated the opportunity of coming to talk to somebody anonymous where it felt safe:

*'I could start to feel. . .and see the light and. . .move up to a place where I was safe rather than be in a hole thinking, you know, there's no-one here to help me.'*

Dani's experience of comfort, security, and help and the links made with her own daughter suggest that her therapeutic relationship had a significant infant-mother dynamic.

Although Tom's experience was slightly different, the connection he developed with his therapist was of a similar infant-mother relationship. Having chosen a snake that reminded him of the snakes and ladders theme of life, Tom continued to hold the snake whilst telling me of his female therapist whose presence generated an eroticised transference within him. But rather than overtly sexual it appeared to indicate early dependency and nurturing needs. That his therapist accepted and valued him revitalised Tom:

*'the fact that somebody was there to reaffirm that I was worth knowing, that I was worth something was itself a grace. . .not just a healing grace but a...you know, a gift of synchronicity.'*

Not only was there a sense that Tom's therapist essentially became the mother that he was yearning for, but he also felt a spiritual connection with his therapist. Interestingly, in the interview a similar transference occurred and I too was linked to his mother: *'You have a very kindly face and you do remind me of my mother.'*

Kira's therapist became closer to her than her closest *'sister'* and, whilst a sibling relationship is described here in contrast to a maternal transference, yet again therapist warmth is portrayed as: *'the sun in the sky'*, and her therapist as a safe support. At the opposite end of the spectrum no maternal transference seemed apparent for Mike, Jane, Tess and Ed. And Ed, disappointed by his therapist's impenetrable manner, described him as a cold *'stone'*.

## *2.2 Building trust together*

Here there is a sense of an evolving two-way trust between clients and their therapists that very much centred on the weighing-up of power and control differentials. Trust developed from the therapist demonstrating constancy, reliability, confidentiality, non-dominance, strength, honesty, and transparency through self-disclosure. And many interviewees consciously looked for commonalities so that they could transfer positive associations from other close relationships onto their therapist. Again there was a range in emphasis between accounts, but overall a subtly different and more equal human-to-human, collaborative partnership was developing in this

theme.

For Lisa, trust was crucial as it had been missing in her life. She was surprised to find that not only could she trust her male therapist but that he also trusted her in a two-way process:

*'it was building trust[...] Both ways. Which was kind of a first because I had trust issues with previous partners and therefore...because of the father, so it was both sides. So even though I want to trust. . .somehow . . .they didn't trust me. They didn't really listen. So for the first time I didn't feel that[...] I felt I have his trust straight away.'*

Lisa visualised this trusting process as a reassuring connection in which both participants were active and each had a measure of control:

*'like the tennis thing or the elastic band. It just comes and goes and it doesn't stop unless you say so. Kind of a reassurance that it's there. Kind of unconditional trust which is nice.'*

Roza similarly felt in control and conceptualised their relationship as respectful '*professional friends*'. Her therapist allowed her space and was not intrusive: '*she would not hurt me or pull me where I don't want.*' Empowered with having choice Roza held '*the key*' and was in charge of her: '*rooms wherever. . .in my body, in my mind, in my soul or just my memories.*' She felt she '*clicked*' with her therapist who demonstrated reliability, confidentiality, mutual respect and honesty.

Importantly for Roza, the small self-disclosures from her therapist were reassuring, welcoming and equalising, making her therapist '*real*', more '*human*' and not an '*expert*.' This evolving rapport enabled Roza to open-up more deeply:

*'she opened for me a little bit. She trust [sic] me too. . .if she wouldn't have done at all, I don't think I could talk about everything.'*

Pat also discovered early on that her therapist was someone who could be relied upon: '*I knew I could trust her*'. Although Pat placed less emphasis on the development of trust than on the maternal transference, nevertheless its importance was stressed when, later in her course of therapy, Pat became discouraged believing her therapy was: '*a complete waste of time*'. Having trust in their relationship enabled Pat to convey these negative thoughts to her therapist:

*'It was fine because erm...I did feel I had a completely straightforward relationship with her that I could actually say anything. . .anything.'*

Feeling disconnected and disempowered, Tom felt that he had to '*learn to interact*' in order to avoid doing '*something wrong*'. Taking two miniature figures from the object-tray Tom demonstrated that originally he felt that he and his therapist were positioned face-to-face but, as trust developed between them over time, they became equal and ended up working '*side-by-side*.' He felt that not only was it the '*constancy*' and '*regularity*' of the therapeutic process that altered their positioning but that he actively looked-for and found connections between his therapist and

himself: *'It was actually finding similarities rather than the differences'*. For Tom it was important that he could find someone whom he could *'walk parallel with'* in order to be able to talk intimately. He associated this relationship with priests with whom he had previously consulted and, picking up a car from the object-tray, Tom also linked his therapeutic relationship with his *'big brother who always helped me'*. Thus Tom found that he could transfer positive attributes from past close relationships onto his therapist.

On the other hand, Kira and Jane found trust difficult. Initially Kira held the power by controlling her sessions: *'would shut down her questions'* and *'jump in and out of things so that you never get a full picture'*. Jane, on the other hand, chose a gentle, friendly, little puppy to describe her therapist but altogether found her therapist's *'way of working quite confusing'*. Not getting the reassurance and advice that she wanted Jane felt *'in a knot'* and became increasingly frustrated with her therapy. There seemed to be a sense of abandonment in Jane's description of her experience of therapy: *'you can talk to a dog till the cows come home but you know that the dog is not going to talk back to you.'*

### 2.3 *Feeling heard and understood*

In this theme weight is given to the nourishment and validation that the interviewees felt through being fully heard and understood without judgement by their therapist. This essential component deepened the therapeutic connection and facilitated deeper disclosures and emotional expression.

Not wanting a disinterested robotic therapist, *'a machine'*, Lisa felt reassured to find that she was not patronised but taken seriously and held in mind. It was important that she was respected as an adult and not *'judged'* or *'told off'*.

*'I would see that he would really understand, not just saying, you know, just "Oh yeah, yeah" [...] I felt he was listening to everything and over the few weeks I was surprised that he would remember so many things.'*

Ultimately Lisa felt cared-for by an empathic and generous therapist:

*'he cared and he really wanted to help and he was trying to get to really know me and yeah...just try to not hear but really listen 'cause there's a difference between the two[...] He was listening to me and he was helping me without asking for anything else.'*

Dani felt herself met by her therapist in the depressed emotional state she was in: *'she understood and she listened and she didn't judge me and she didn't offer me any solution.'* This validation enabled her to re-connect with another, in contrast to feeling disconnected when her depression had been dismissed by her friends. Tom had a similar experience with friends and,

like Lisa, was surprised by his therapist's active listening: *'that the more I talked the more I was surprised by the fact that somebody wanted to listen.'* Feeling nourished: *'being heard is also about being fed with time'* Tom summarised his therapeutic experience as: *'very seriously I have been heard.'*

Pat too felt appreciative of her therapist's attentive listening, insightful reflecting, understanding and affirmation:

*'I felt grateful for the level of attention that she erm. . .that she paid me which felt quite extraordinary[...] she would occasionally say things which gave me insight which erm. . . made me realise that she attended to a lot of erm. . .what I'd said or a lot of what I'd felt[...] she would manage to find something to appreciate and remind me of that.'*

Tess found it especially helpful when her therapist reflected and fed-back thoughts, images and feelings as it validated her experience:

*'[She] was quite good at picking out patterns of things and just reflecting back, you know, things that I said or how they made her feel. And she said, very early on, about this tightness[...] that was the image that came into her head.'*

Although Jane disliked her therapist's silences, she nevertheless appreciated the value of having the space to talk about herself and her problems. She particularly felt understood at the final session, when at last she was able to admit to her growing anger and frustration with therapy to an understanding therapist who was robust and did not withdraw: *'and we sort of concluded a few things[...] the last session was good.'*

Ed however felt frustrated by his therapist's reserve, silences and lack of theoretical input:

*'He wouldn't. . .erm . . .very often offer an opinion or something[...] I guess initially I was hoping for erm. . .more input ..more input from my therapist.'*

Impatient and desperately wanting to reach a deeper understanding of his psychological processes, Ed experienced his therapist's way of working as frustrating and repetitive such that he could anticipate his therapist's next comment. Ultimately Ed felt that he was heard but not particularly understood by his therapist.

## *2.4 Overcoming fears and risking self-exposure and vulnerability*

From the narratives it is clear that, to be able to talk intimately about themselves, clients needed to feel engaged in a secure, caring and trusting relationship combined with being heard and understood without disapproval or criticism. Only when these processes were sufficiently operating could clients overcome their fears and risk self-exposure and vulnerability. Vivid



descriptions illustrate the range of behaviours and cognitions interviewees experienced in overcoming their fears, anxieties and doubts.

Kira, who was so frightened, could *'feel the build-up'* of tension within herself until her fear discharged after four months into therapy:

*'I was so scared I controlled every single meeting that we had. As much as my counsellor would try to engage in different things I controlled it. And it wasn't until probably about four months in. . .to it that, I don't know what happened one day[...] It feels like a bit of a blur but I just like. . .it was like I walked into the room. The door shut. And my boundaries just came down and I don't think I've ever cried like I've cried. I couldn't even speak and I don't know. . .I can't even tell you what triggered it off but something happened and the fear almost was like coming out of me but I knew I needed to do it because I wasn't getting anywhere.'*

She vividly described her *'intense'* catharsis in terms of an erupting *'volcano'* and *'hot pools'*, and *'Whoooooooooh! It just was like a whirlwind'*; and her self-splitting followed by integration was graphically illustrated:

*'like I was this very. . .like a rock. . .and then a hammer came and hit me on the head and I split in half and the. . .rock Kira stayed over here and the sensitive Kira that I know that I am and one that has been crying out for help hopped into my body and said, I. . .I need help. . .really desperately, like I'm just not. . .I'm not normal basically...like (laughs). . .Whoh! Not...I'm not right.'*

As her mental chaos began to clear over the following few weeks, so empowerment, increased well-being and self-control followed:

*'the more I talked about this horrible hole I felt like I was in the more I. . .the more I started to feel better[...] it makes me feel ten times better about myself, about where I'm going and I can. . .speak and use the right words and stay calm.'*

This powerful cathartic experience released Kira, enabling her to start the work of therapy.

Having come to therapy in crisis and desperately needing help Lisa felt that she had no option but to yield to *'going in blind'*. She had felt *'brave'* in risking feeling *'naked'* and *'vulnerable'* when crying and feeling *'kind of a wreck'*: Gradually as it dawned that rather than being hurt she was being helped, she began to feel safe. But paradoxically and poignantly another fear surfaced in Lisa for, having now gained her therapist's respect, Lisa subsequently feared its loss through confessing her more self-destructive misdemeanours with the occasional expletive. Difficult though it was, Lisa wanted to be truthful and tell him *'everything that happened'* but she feared breaking their bond:

*'I didn't want to break that thing that therapist-patient, I don't know what, but I didn't want to break that so I was trying to be as sincere as I could but hoping, like, please don't tell me off. Please keep helping me.'*

Receiving love and validation from her therapist and feeling safe enabled Pat to drop her social 'veneer' and express her normally hidden authentic self. As Pat reflected on how she became connected with her suppressed thoughts and emotions, she became deeply moved - as did I:

*'I was trying to deal with it all by reasoning. By thinking it through[...] And what I didn't do was to. . .stop and actually feel what I felt. (Pause) Except here. (Cries) And it was important[...] That was really the biggest thing – that really was the biggest thing. It was just completely safe.'*

Whereas Dani, not liking her therapist and not feeling safe initially, demonstrated with a syringe from the object-tray the tension between them:

*'I was trying to draw stuff out of her whereas actually it was the other way round. She was trying to draw stuff out of me.'*

But after crying in the third session and for the first time feeling comforted and helped by her therapist, Dani's attitude changed and she found that being vulnerable strengthened their contact and enabled deeper exploration: *'and that's when we started to work together.'*

Roza also reported feeling securely supported by her therapist in an interactive process:

*'we managed. . .I managed to say a lot of things and she helped me and she didn't show me that it was, you know, tough for her or something.'*

As Roza relaxed into the process her fears also dissolved: *'the boundary. . .the thing. . .it just went. It just felt good to talk to her.'*

Socialised into believing that talking about sex was unacceptable, Tom had to challenge a core belief and *'face the obvious'*. He took the risk of disclosing his erotic feelings towards his therapist and had to manage his fears about being judged for this behaviour:

*'I was overcoming stuff and dealing with the depth[...] It was exactly what I had to address so it was the right time and the right place. I felt[...] I felt I could address something which I couldn't address anywhere else[...] So it was the right person at the right time for me, yeah.'*

Tess, Mike and Jane were reluctant to trust the process of exploring more deeply into themselves and their lives, with the result that they felt disappointed in not reaching the roots of their problems. Tess felt that she was committed but from her account it seemed she lacked confidence in her young therapist, and her wish for a cognitive quick fix may have inhibited her such that she could not let herself become vulnerable and work at a deeper emotional level: *'I was very motivated to fix it but she wanted to spend more time exploring'*. Not only was there a conflict of aims but there also seemed to be a disconnection as Tess mentioned that she felt uncomfortable sitting on chairs that were set too far apart. Similarly, Mike acknowledged his avoidant behaviour; that staying intellectual in his therapy had been *'slightly self-indulgent'* and

*'intellectually sort of pissing about'.* On the other hand, Jane's anxiety increased to such *'panicky'* levels that she thought she was *'going mad'* with her overwhelming ruminations. She became so frustrated that she terminated therapy on her eighth session. Her fears about exploring a very sensitive and potentially painful issue could not be overcome.

Ed, however, realised that, in order to benefit from the therapy he was having, he would have to give up his impatience, frustration and desire for *'rapid progress'* and accept the way his therapist was working:

*'I just came to accept that this is just the way it is[...] without any expectations and just see what happens[...] I became more relaxed about it[...] more patient with the process.'*

But underneath Ed was disappointed. He had wanted to go to deeper levels of understanding and believed that his progress was impeded by his therapist not giving him the psychological input that he wished for.

### Superordinate Theme 3: Journeying together for Personal Discovery and Change

This focuses on how interviewees experienced their relationship with their therapist; how their thinking was stimulated in a different way, and what they felt they had gained from therapy. Regardless of whether interviewees overcame their fears and doubts, each reported benefits in their well-being, with increased understanding and personal growth. And for those that did manage their fears the gains were significantly greater. Again this superordinate theme illustrates a spectrum of experiences within each theme.

#### 3.1 *Showing me the way to go*

Whilst those processes from previous themes were still operating interactively for eight interviewees, the relationships with their therapists shifted into a different phase. In this theme there is now more of a sense of working together collaboratively to achieve the specific aims of each client.

Dani, having overcome her fear of vulnerability and feeling more relaxed with her therapist, the work of therapy became very much one of investigation. She described her therapist as an extractor and explorer and demonstrated this with a syringe:

*'I found what I was coming out with and what I was going away from the sessions with was actually already inside of me but it took somebody else to actually examine it and I suppose draw it out of me'.*

Dani further elaborated that it was not a process whereby her therapist solved her problems but rather her therapist facilitated Dani to find the answers in herself. In this relationship dynamic, her therapist became a helpful guide and shining light during a difficult period in her life:

*'she helped me to open some doors. She helped me to close some doors. She helped me to unlock some things inside me[...] I wanted someone to hand me the key to unlock the door whereas actually she showed me the way to go so I could find the key. You know, she's not. . .she wasn't just going to hold out a plate with a key on and say, right here it is and open the door. There's all the answers to your solutions. So she just sort of, I suppose, just shined the light, you know, to show me and say right, the key's down that road'.*

Roza, picking up the skeleton, wanted help from her therapist to 'tidy up' her childhood hurts: *'I thought I had all the pieces but I didn't know how to put them together'*. Her intention was to clean and lay her 'old bones' to rest; to address her past hurts and *'to put them in peace somewhere'*. She, like Dani, also described therapy as opening 'a door' to uncovering herself. Selecting an amethyst gemstone to represent her 'pretty things' that had in the past been culturally dismissed as worthless, Roza tearfully told me that how her therapist had not only helped her to discover the hidden and split parts of herself but also facilitated her to acknowledge and value all of herself:

*'my therapist helped me to see that I can be proud of my good things and not just hide them behind the door.'*

Her integration felt liberating, bringing Roza 'joy' and 'happiness' and she conceptualised her therapist as a wise guide accompanying her on her journey:

*'sometimes she was like the older women who guided me with her wisdom[...] and showed me where to go.'*

Roza also depicted her therapist as a mid-wife giving 'birth to your thoughts' who 'helped me to bring up painful things and good things'. Though therapy was 'tough' at times, Roza recognised the benefits, and holding the syringe she symbolised the process as:

*'flushing me out of a few things, of giving me good injections just to help survive[...] we have to have sometimes painful injection to. . .to gain something. To get protected.'*

Pushing air out of the syringe also reminded Roza of how her therapist empowered her by giving her a voice: *'I could speak out because of her.'*

Holding a ladder and key, Lisa softly and tearfully emphasised, with repetitive speech, how her therapist had rescued her from a dark, chaotic mess towards a more positive future:

*'I was trapped in all those feelings, all those bad things, and yeah, he helped me to open that door. And (sighs) that's it. That's it[...] Ah just this feeling of being trapped. Yeah. Just being trapped. Like not knowing what to do to get out on my own'.*

Lisa reflected that therapy was a joint endeavour: *'it's something you. . .you're going through with someone'* and only as good as the quality of their relationship:

*'It's more of an exchange and yeah, like the tennis thing again. If, you know, if he throws it nice and in a good way, like yes, it's going to be easier for me. But if he doesn't do it good, then I'm gonna miss it and then lose the game.'*

Fortunately for Lisa there was a good-fit: *'we had that, yeah. . .that same goal of making me feel better'* and implicitly she sensed that in their explorations he was guiding her and containing her so that she did not get lost in her mess:

*'I could feel there was a certain organisation, like in. . .which direction he wanted me to go, or explore more one thing[...] It's a it's kind. . .you know, if you're messy you do paint everywhere but actually you have to put them back on the canvas and try to stay within that frame. So that did help a lot not to get lost in too many things.'*

Describing him as a *'dictionary'* and a *'helping hand'* he facilitated her to find the right words and meanings to give to her internal processes; through increased self-understanding Lisa gained insight and contentment: *'more knowledge about things but in a happier place'*.

Emotionally Tom felt he was *'a lost child'* needing help: *'I came not to heal but to be healed'* by the *'agent of help'*. Tom similarly described their relationship as collaborative: *'an interaction rather than a sort of this is what you should do'* directive or tenet. Such was the quality of the therapeutic dyad that it enabled him not only to overcome his shyness of discussing sexual issues but more significantly to address his erotic transference towards his therapist. He was facilitated to make links with his avoidance and withdrawal patterns, and to become more authentic and fully present in the moment, to come out from: *'hiding behind a mask and not being here'*.

For as long as she could remember Kira stifled both her emotions and her voice, hoping that eventually her negative thoughts and feelings would disappear. As a result of this suppression Kira would *'torture'* herself in her thoughts and it was only when she let down her defences in therapy that Kira realised how angry she was: *'I. . .I. . .had no clue as to how much of an angry person I was inside. No clue at all.'* Kira symbolised therapy as: *'a clear point in my life that made things clearer all of a sudden'*. Her therapist brought clarity to Kira's understanding of herself and her processes:

*'she's helped me understand that it's ok to be the way I am and it's ok to. . .want people to understand the way I operate'*.

After Kira's defensive *'wall'* had been broken she began to enjoy her therapeutic journey: *'I loved returning. That was the thing. I loved it[...] I felt like I was getting somewhere'*. And by the end of her therapy Kira had internalised her therapist:

*'I still think about things that she says, that she has said to me or, you know, little things that I think, wow! She was really good. She helped me a lot. You know, little things like*

*that. . .that I think about, that, you know, I will always cherish. Really some fond memories.'*

Likewise Pat came to therapy in distress, emotionally confused and feeling stuck. Picking up the lantern from the object-tray she also depicted her therapist as an illuminator and clarifier:

*Just gave me a different way of looking at things. Helped me to stand back erm. . .more and helped me to, helped me to. . .yeah, just helped me to think differently.*

Pat's therapist facilitated Pat to let go her anger and resentment and regard others with more understanding: *'I'm much more able to accept and respect them as different people'*. Her therapist was an educator providing new perspectives that encouraged her to look at: *'other possibilities about ways to learn. Ways to change.'* Through highlighting Pat's underlying and conflicting emotional processes she helped Pat find her authentic self and her voice:

*'one of the things that she pointed out that I've never really realised that seemed very important was that[...] I was so scared of things going wrong that I couldn't actually be erm. . .I was sort of. . .(sighs). . .I couldn't actually be myself at all. I couldn't say what I wanted.'*

By being given space and empathic attention Pat was able to experience her emotions fully and reach a deeper understanding about herself. Moreover she recognised the deep attachment that she had formed with her therapist in this process of contacting her feelings:

*'She'd given me the opportunity to realise that and to feel that and I really appreciated it so. . .so it was sad to say goodbye to her because of her connection with me and something important to me'.*

Tess was looking for a magic fix, a *'perfect person who's going to unlock or help me unlock whatever it is'* someone like a *'Darth Vader'* who, with his light source, could *'shine a light on something'* and expose the source of her problem. Although they did not find the source of her problem, Tess found her therapist to be a collaborative thinker, offering different perspectives and highlighting her repetitive patterns:

*'...they weren't sort of blinding revelations but it was kind of erm. . .just putting ...conceptualising them in a different way or putting them with or saying them in a different way of something. Erm. And just focusing in on a few things. . .which was actually quite helpful.'*

Working jointly they developed strategies for Tess to slow down and relax: *'It was giving me avenues to. . .to pursue. . .to work on'*. Throughout it all, Tess was aware not only that her young therapist was possibly thinking about her in-between sessions but there was also a supervisor in the background. For Tess, to have an extra mind on her processes was empowering:

*'I feel like the therapist tried really hard. And at times was successful and we moved. We did move. I did move a long way and I got a lot out of it but I still. . .I was really glad that there was that person behind 'cause sometimes I used to feel that she came to the next session with something that had been. . .but maybe she'd thought about it or maybe it'd*

*been discussed, I don't know[...] But something that erm. . .wasn't there last time[...] That was powerful.'*

Like Tess, Ed also hoped that his therapist had the key that would unlock his cage: *'could maybe offer me the key to get. . .the key to understand. . .what I felt was trapping me'*. Instead Ed became increasingly frustrated by his therapist's cautious approach and lack of interaction:

*'I suppose I would have liked to be challenged more[...] I would have liked to have been erm. . .perhaps been introduced to some type of psychological concepts that I could think about. . .that I could get my head around and start thinking.'*

Disappointed that his therapist did not offer him psychological ideas that might further his understanding, Ed selected a traffic-cone to depict this impediment: *'a barrier, I suppose, to progressing'*. Nonetheless, his therapist took the role of highlighter, focusing on particular aspects of Ed's narrative that helped Ed to recognise certain repetitive patterns in himself:

*'eventually I saw it as insightful when you know he did comment on certain things, especially things that I'd said, sort of said, time and time again and I was. . .he was commenting on it again and again. . .and I was noticing patterns.'*

Ed's therapy ended after twenty-two sessions, by which time he concluded that he had enough knowledge to try and *'sort of crack this alone.'* Having gained insight on his repetitive patterns, there was a sense that Ed felt abandoned to stumble alone in finding ways to change his old habits rather than being helped to do so by his therapist:

*'perhaps I found the key but (laughs). . .I'm not skilled at using the key[...] I'm still a long way to go in learning how to use that key and erm. . .and get out of the cage[...] It's one thing noticing that it's . . .that I'm doing it but. . .how. . .how do you change it?'*

Although some clients may have an unaware or unacknowledged reluctance to change and may not be at the right stage of readiness, in Ed's situation it seemed that this unaddressed rupture from having no discussion was possibly due to the trainee practitioner's stage of training.

Whilst Mike held on to his scepticism about therapy, he appreciated his therapist whom he regarded as a *'fellow teacher' and 'co-investigator'*. Having realised that he was not going to get a diagnosis or any answers, he depicted his therapist as a container, observer, highlighter and tracker: *'keeping up on the process stuff and making it useful[...] sort of keeping track of what's going on.'* He very much enjoyed sharing his cognitions with his therapist but would not allow her to work with him at deeper emotional levels. At times his therapist challenged him on his behavioural patterns evident in their sessions, such as his use of humour. And although Mike was dismissive about any negative childhood impact, they nevertheless jointly constructed how he might have felt as a baby in his particular situation *'feeling buffeted by the environment rather than being in control of it.'* Mike's metaphorical description of therapy was rock-climbing where *'you're going to this place from this place'* in a focused way.

Jane's relationship with her therapist was not a good fit. She had come to therapy seeking an answer to her anxieties and she picked up the puzzle from the object-tray to illustrate her feelings of confusion. Laughing nervously she told me:

*'I thought I suppose it would come out all nice and I'd feel a lot happier and I'd find the solution and I'd feel happier and er. . . breezy, I suppose. And things would feel a lot more pretty and happier.'*

And whilst Jane's therapist said '*a few useful things*', ultimately Jane was disappointed with her therapy as not only had she had not received the advice and reassurance that she desired but the process had at times intensified her anxious ruminations.

### 3.2 *Setting everything whirring and thinking*

This theme encapsulates how therapy encouraged all interviewees to think differently about themselves, others and their lives. A point was reached that instead of seeing therapy as single discrete weekly units, clients began to take more responsibility by reflective activity in-between sessions. The different perspectives offered and questions asked by their therapists helped clients to find new meanings and emotional links that enhanced self-understanding and strengthened self-belief.

Dani summed it up well:

*'I started to come away from the sessions and actually think about what we talked about. . . rather than push it all to one side.'*

Importantly she would bring back her thoughts the following week for more discussion '*it really did set everything whirring and thinking*'. And there was also a sense that a self-reflective and focusing process had been generated within her that had not been there before.

As with Dani, Tess's self-understanding was also developing. She too was reflecting between sessions, noticing patterns, making links and recognising that she had different choices:

*'I think I'm finding out a bit more about how, you know, what my style is, really, and I don't have to do all this. . . stuff. I can do it in a different way really. So. . . it was. . . so it was partly. . . so we did think about things[.] We were talking about that sort of stuff and issues came out of that or patterns came out of that.'*

New perspectives offered by her therapist stimulated Tess's thinking: '*she said them in a different way or we talked about them in a different way from how I talked about them before*'. And Tess was also challenged by her therapist's questioning which occupied her thoughts afterwards:

*'There were some really good questions, you know, that [therapist] would ask erm. . . and then I remember one real moment that she asked me this question and I couldn't answer it.'*



Tess found that inter-session reflection proved insightful, deepening her understanding by the associations she was making:

*'Sometimes I couldn't think of the answer that week but it would stay with me during the week. And I would be thinking, ooh yes, that's interesting[...] and quite often it would have erm. . .kind of shifted something. So it sounds cliché but some thoughts would have been triggered by it or, you know, would have set me off thinking about something or, found some other links.'*

She also recognised that this reflective work was not only a serious motivating factor for returning each week but showed her level of commitment:

*'And reflecting on things in the meantime, coming back having talked about something or. . .you know, not just coming back and thinking, oh, what did we do last week?'*

As Lisa became more articulate about her feelings in sessions, she found that with her therapist's help she also was able to make links with her life and behaviours:

*'because he was putting the real words on different emotions so over the weeks I realised, oh yeah, actually there is this and this and this as well.'*

As a result of becoming more aware of her psychological triggers Lisa also experimented between sessions, testing herself: *'I was trying things as well. Put myself in certain situations and see if I could detach from them'.*

Roza described the thinking process as a kaleidoscope where collaboratively they teased out and made sense of her childhood:

*'I give [sic] the puzzles to her and she just. . .I mean, I gave her just colourful stones or different which didn't make sense and she just held that with me and we could see the picture there. Not always good but we could always find a meaning of the picture which I think was important.'*

For Kira, it was only after her catharsis at sixteen weeks that she awakened to what therapy was about:

*'And then all of a sudden I was like, 'Mm. Do I have to really talk about myself?' (Laughs) 'And my feelings?' And then that was it.'*

From this point onwards, Kira became fully involved in her therapy. Using her arm to gesture a zig-zag she described how she found it a stimulating but tough roller-coaster of a ride to make links between her emotions and her personal life events:

*'And. . .the. . .the hard thing was that those sessions, from then onwards, became like 'whooh!'. . .some days would be good and I'd talk about something and something would trigger inside me that I would think about something else and I would talk about that.'*

Pat too began to think about her emotions in a different way and to experience feelings that she had hitherto avoided:

*'I kinda knew at an intellectual sort of level that I felt shocked and I felt distressed[...] I didn't actually really feel it until I. . .until I, yeah, until I came to therapy. I didn't actually really feel that.'*

Whilst Pat had an intellectual appreciation of the importance of feelings, she had not fully understood the value of both experiencing them viscerally and the learning that can be achieved from processing emotions in this way:

*'I know that what I'm sort of more aware of now is, in a bit more of a meaningful way, in a more of a meaningful way, that there is somehow more clarity and more solutions and more to be learned about, you know, how to be and how to change or how to make things different by being able to erm. . .by being just more in touch with what I really feel.'*

On the other hand, Ed found that as he was becoming more aware of his cognitive and behavioural patterns he was beginning to question why he was constantly having negative thoughts and behavioural patterns: *'why things like that kept recurring in my thoughts. Why this sort of seemed to happen again and again'*. Whilst he felt that some sessions were unproductive, at other sessions he felt invigorated having discovered a different perspective: *'it was enlightening'*. These were the moments when Ed left the session thinking: *'well, you know, that I hadn't thought about it that way before'*.

Finding patterns with her therapist helped Jane reassess her life-style and recognise her strengths:

*'we looked at all those things and I was like, yes I do do that. I do do things. You know, I do do positive things in my life and it made me realise that.'*

And the helpful positive perspectives offered by her therapist developed her thinking: *'that, in a way, really helped me, because that made me think, yeah, that's true actually'*.

However some probing questions caused so much consternation that Jane felt overwhelmed:

*'I came away and questioned myself over a lot[...]. So in a way that played on my mind a lot.'*

Whereas Mike enjoyed: *'the weeks of quite hard thinking things. I liked erm the multi-level thinking about thinking different things'* and found it: *'interesting putting some things together'*.

And, although reluctant, Mike nevertheless started to think about childhood influences:

*'made me think a bit more about that which. . .how some of those quite arbitrary choices your parents make might really affect the way you function and stuff[...] it was a new way of thinking about stuff, an entirely new way of thinking about stuff.'*

Excited by this new perspective, Mike found he was making cognitive connections accompanied by visceral shifts: *'there's almost like an internal reward when that happens'* as if pieces of a puzzle were falling into place.

### 3.3 *Becoming myself*

In this theme there was a sense that the interviewees recognised that personal growth was a never-ending process. However after their course of therapy, not only did their self-understanding improve through increased self-awareness and self-compassion but they generally felt calmer, more balanced, jollier, lighter, and more authentic, with strengthened self-belief and enhanced communication skills.

Mike felt that making the decision to have therapy was the first step in his taking control of his problem. Paradoxically he was also aware that therapy was a process of letting go, although he did not fully achieve this in his therapy:

*'I guess it's partly a taking control thing but it's almost making a conscious decision to maybe surrender myself to a process.'*

Having an image of his ideal self, a sort of Doctor Who character who is *'very bright and fixes things[...]* but in a sort of low-key sort of way' Mike felt incongruent, that his current self was *'out of focus, out of tune'* with his ideal self. After his twenty-four sessions Mike felt more integrated: *'better than I was in terms of original problem'* and more connected with his family and work. He described his self-development as a journey, a long walk towards a mountain where *'I'm not meeting myself I'm becoming myself. . . sort of changing'*.

Feeling empowered after twenty-four sessions Roza described therapy as opening *'a door'* to discovering the rejected parts of herself that were keeping her stuck:

*'One side it. . . I had some strength which I didn't know. . . on another, I had some weaknesses and some things which I push away and were stopping me from moving forward.'*

As Roza looked over the objects she had chosen she gently re-positioned the amethyst gem alongside the pebble to demonstrate how she now felt integrated: *'It helped me be myself'* with increased self-compassion: *'I don't judge myself so quickly and so tough'*. Additionally Roza's self-awareness was enhanced, as well as her trust in understanding and managing her feelings:

*'I think I have some more skills to deal with things. My emotions, I know how to tidy up them, or how to understand them.'*

Dani came to therapy feeling depressed and anxious, and after a course of twelve weekly sessions her self-perception had altered:

*'I just feel so much happier[...]* I think having the therapy made me realise that I wasn't a failure. That I had other attributes and I have other successes behind me rather than just focusing on the one thing.'

Therapy increased her self-esteem and self-belief, helping her to come to terms with her current life, and moreover gave her choice. It *'opened the doors'* for future possibilities. Through the therapeutic process Dani's anxiety lessened; she *'found peace'* and said that *'the therapy has taught me to calm down a bit. . .without the pills'*. Selecting the scales and the eye-ball from the object-tray, Dani reported that now she feels more balanced, her sense of humour has returned and that she *'can see things a bit more clearly'*.

Over the course of twenty-four sessions Tom emerged from the depths of depression with more energy and confidence: *'I was slowly coming out from you know being at the bottom of the sea. Erm I have more social interaction now'*. Additionally, he became more self-accepting and outgoing, with increased self-esteem *'that actually I am worth knowing, I am a good person[...]* My nihilism has turned into social determination to know people'. His sense of humour returned and his overall description of his experience of therapy was that *'it was something cathartic'*.

Picking up the red heart from the object-tray Jane described how in eight sessions she had become less analytical, less self-critical and more self-compassionate and positive:

*'I'm just kind of just enjoying. . .just at the moment enjoying being myself[...]* I'm nearly there at the moment and I'm happy at the moment. So, you know. . .it's good.'

Jane had gained in understanding and self-acceptance:

*'I feel like I've just been a bit of a pleaser in the past relationships and like, now I just think, I just want to be myself and, you know, just want someone to accept me for exactly who I am; and I am who I am.'*

Wanting to grow, blossom and feel more positive Ed learned that self-development was a continuing process that he could practise on his own:

*'I knew that the more I. . .the more I actually searched inside myself. . .and. . .sort of drilled down to the real truth. . .of what I was feeling and what was going on inside that I'm. . .I'm helping myself in doing that.'*

Ed concluded that only he was trapping himself but the process of releasing himself was proving difficult: *'therapy can't get me out of the cage. I can only do that. I've got to do that myself somehow and erm. . .that's the tricky part'*. Acknowledging that his self-awareness was developing, Ed picked-up the scales from the object-tray to demonstrate how he was *'not balanced at the moment'*. He hoped that by being kind to himself he would: *'give the other voice, the compassionate voice[...]* more weight and it will become more balanced'.

Lisa felt that through the therapeutic relationship she was re-constructing herself: *'I was building some things with him. I was building myself better'*. She developed self-understanding,

autonomy and choice:

*'the therapy gave me more strength and understanding of what I really wanted and needed in my life and what I had to avoid[...] more freedom and more confidence in myself that I know I have the power to take myself out of certain situations. I know I have that now so I need to use it more often, so yeah it feels good.'*

Choosing a lion and sunflowers to depict her empowerment, optimism and lightness after her earlier thoughts of darkness and death, Lisa reflected: *'it's like I have the same life but in another country'*. By the end of her thirteen sessions, all Lisa's self-destructive behaviours had stopped and she felt congruent, free and in harmony with her environment: *'like a fish in the water[...] you know, compared to the cage thing'* that she had felt at the start.

Out of confusion emerged a more enlightened and integrated Kira:

*'I think, I will always be the strong Kira that I have always grown to be but the soft Kira or the Kira that needed help has come out a lot more and a lot stronger than the other Kira before I came into it.'*

Kira felt that a weight had lifted from her shoulders leaving her feeling lighter and younger. In becoming more aware of her behavioural patterns, Kira's relationships had improved as her fear and aggression abated and, with her increased confidence and enhanced communication skills, Kira developed more openness and authenticity:

*'now, I feel like I can talk about my feelings easily. Sometimes I still feel sad and get upset but I feel I can talk about it. Before, you'd never get my...you'd never get my true feelings. I might have been able to talk about feelings but you never actually got my feelings. . .you never got the truth from me.'*

Before therapy Kira: *'was in the deepest part of that black hole'* feeling worthless and contemplating annihilation: *'a depressed, lost soul. No good for anyone[...] feeling like a failure'*. But *'now I'm like, hmm. Of course I want to be here. I love it. I like life. Actually life's quite cool'*. Kira described therapy as an *'incredible'* process that had *'saved'* her: *'I don't want to go back into that old Kira. I want to stay this Kira[...] I'm so. . .just in a different space'*. Feeling transformed and empowered, Kira's idea of her new self is a field of sunflowers with a path of future possibilities:

*'with a path and a house at the end of it. And, you know, like. . .it kind of felt like, to me, like. . .an opening. . .the start of something that was quite big for me.'*

For Kira, sunflowers depict happiness: *'They bring a smile to my face. They make me feel like there is light'*. Kira left therapy with a buoyant feeling that it was *'all coming together slowly but surely'*.

Before therapy Pat had various roles that *'clouded'* her authentic self such that she was not in contact with her feelings. Tearfully she told me that therapy had given her the space and time to

feel and express the sadness, guilt and anger that she had been suppressing for so long: *'I felt connected to what I really felt and that seems very powerful. Important'*. The discovery of experiencing herself deeply was surprising, releasing and empowering: *'that really felt like a gift actually. That really did feel like a gift. I'm really very, very grateful for that'*. Through the therapeutic process, Pat realised how much she missed by intellectualising, rather than taking time to pause, reflect and becoming consciously aware:

*'I think what I often have not done in the past and don't do still, most of the time, is actually erm. . .be aware of just where I am. And what I'm feeling now and what that actually tells me rather than endless thinking and reasoning.'*

By becoming able to process her emotions Pat became more mindful of life around her: *'it's not stopping to have a rest, it's stopping to actually appreciate things'* and moreover, as a by-product, happily discovered that her sleeping pattern had greatly improved.

Disappointed that her therapist had not found the key and shown Tess how to release herself from her locked 'cage' of stress and anxiety, nonetheless together, over the twenty-four sessions, they developed strategies that Tess was continuing to put into practice: *'So I'm feeling if I carry on with some of these sort of techniques and what have you. . .that hopefully it will all kind of come together'*. Although feeling disappointed in not reaching the core of her anxiety, Tess nevertheless was surprised to find her mental state had improved. This was evident when she suddenly caught sight of her reflection: *'I could see myself in the mirrors and I thought, how am I looking then? I'm smiling.'*

## **4.2 Examples of the impact of my enquiry method and the research relationship**

I chose the examples below to demonstrate both the impact of my enquiry method and my part in the research relationship.

When asked to describe her experience of her relationship with her therapist Kira's hand hovered over the black cat for a few seconds before picking the cat up. Holding it between her fingers, Kira slowly and hesitantly described how she saw herself as dark, sneaky and more powerful than her therapist. To help Kira to expand on this and describe a relationship, and thinking that perhaps there was no object on the tray that suited her, I asked how she would paint her therapist. She responded that she saw her therapist as an easy target. Again, thinking about their relationship, I then asked if an animal came to mind hoping that this time she would match the black cat with another animal rather than an inanimate object:

Kira: I don't know why I'm drawn to it but I feel like it's almost like a . . .a . . .something of the night. . .something that's a bit erm. . .what are my words I'm looking for? Come on, Kira, think. Erm. I can't think of the words. . . like. . . sneaky, like. . .a little, you know, like. . . then you think of a black. . .a dark, black night and you see a little cat sneaking along. Like, I feel like that was me. . .

Int: Ah.

Kira: . . .in the meetings. Like I was very sneaky in the way I controlled the situation.

Int: Right. And who would she be then? If it's not here then how would you paint it?

Kira: Well, like an easy target. An easy prey. Timid. A little bit timid, like a little bit (whispers) quietly spoken...erm.

Int: Is there an animal that comes to mind?

Kira: Well if this was a black cheetah or something (laughs).

Int: (Laughs with Kira) Yeah.

Kira: Well maybe I would think. . . like a wounded sheep or something. (291-301).

An example of how participants used the objects comes from Tom, who having selected the snake, ladder and key from the object-tray is plunged into a stream of consciousness linking each object with associated thoughts. As the key and ladder is put down, Tom is left with the snake which has never left his hand. He associated the 'snakes and ladders' game of his youth with life's undulations and biblical references, until finally Tom reaches the fearsome core concern that he brought to therapy:

Tom: ...snake obviously is a powerful sexual image as well, which is why I've put the key there, 'cos all beasts are to be locked away. Aren't they? Do you think?

Int: Is that how you. . .think?

Tom: Well that's a rather large phallic snake, I have to say. It's a bit of a beast so. . .I'd prefer it if it was locked away, to be honest. It gives me shivers, you know. So erm. . . yeah. . .I'm. . .(pause). . .sexuality is something that I don't talk about very easily. . . erm. . .but that was what the issue was essentially. (70-73).

Roza could not see an object on the tray that described her experience and, as she was struggling to describe her therapeutic relationship, I assisted her by supplying appropriate words. So in a collaborative manner we named the object that Lisa was trying to describe their relationship. Her description also shows her anxieties during the session and also how her therapist helped her to understand and gain insight:

Roza: What is missing. . .you know when I was small, we had a toy. We had like a . . .(demonstrates). . .lunette. . .

Int: Telescope?

Roza: ...something like that but in the end there were, like, stones inside. And when you turned them they changed the shape.

Int: Kaleidoscope.

Roza: Yeah. So that's missing. OK she was like that. Erm and we have a relationship. I think each time I thought, OK today I don't think we can do anything that I brought her. Or I just feel stuck and then in the end of therapy I feel like we moved the pictures and it changed into something which makes sense. (191-196)

There were a few times when participants became tearful in the interviews and, as I paused for their moment of distress to pass, I had to make a judgement whether or not to continue with that particular line of enquiry. Lisa had picked up a gun and a cage. When I asked about the gun, we paused while she cried. As she recovered she indicated with a nod that she was able to continue. Feeling very compassionate and reflecting on how the gun had impacted her, I purposely changed the focus of enquiry onto the other chosen object so as not to deepen her distress:

Lisa: 'Cause it was just really bad. It was really, really bad.

Int: What does the gun signify for you?

Lisa: Ah just everything negative and kind of a last chance. (Cries) Well the obvious is suicidal thoughts. It's OK. It's gone now. That's good. (Cries) They were just really bad. Sorry. (Pause. Recovers self. Smiles and nods)

Int: And the cage? (187-190)

Another example of my implicit behaviour impacting the research relationship comes from Jane who reported therapeutic benefits from the interview:

Jane: ....and I suppose I can sort of see...I can see you can understand how I feel and I suppose in a way that helps me. Just in your face...your expressions and stuff....I can tell how you can sort of understand me a little bit. I feel that from you anyway. (457)



## **5. Discussion**

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### **5.1 Overview**

My aim was to uncover what was happening at psychological depth when individuals entered therapy, how internal conflicts and/or fears influenced their meeting and connection with their particular therapists, and how they perceived the therapeutic relationship. Although it is impossible to gain direct access into the unconscious, as a researcher it was possible to reach some of my interviewees' subliminal thoughts and emotions with the aid of objects as stimuli. Fears, feelings and different relational dynamics were uncovered and expressed, often with a sense of wonderment. My object-tray invited a sense of play and fun into the interview process and seemed to encourage a different way of understanding the therapeutic process. In the debriefing process interviewees reported that they had enjoyed the interview process which had generated new insights and also brought closure to their therapeutic experiences. And I, too, have been happily surprised and grateful by my participants' generous self-disclosures of both their positive and negative experiences and by their continuing interest in participating in my research.

My study provided direct evidence from ex-clients that there is more going on underneath the surface when clients enter therapy, on first meeting and when working with their therapists. It details client fears and demonstrates how these impacted the therapeutic process by preventing full collaborative engagement. Not only did my study show how some clients are active in overcoming their fears but also how the development of a warm and trusting therapeutic relationship reduces fears and aids disclosure. Additionally, my study illustrated a range of helpful interventions found to be therapeutically successful for psychological recovery. I will discuss my findings in detail below:

### **5.2 Clients' thoughts and feelings before entering therapy**

There is substantial research in the hope and expectancy literature to demonstrate that socio-cultural ideas about therapy have a powerful influence on whether people enter and remain in therapy (Constantine and Arorash, 2001; Constantine, 2002), and my findings complement these studies. All participants on entering therapy reported having hopes and expectations that therapy

would be helpful in both reducing their suffering and improving their psychological well-being, and match those attitudes found in a recent study from undergraduates who had never been in therapy (Hill, Satterwhite, Larrimore et al., 2012).

People's help-seeking behaviours are also highly influenced by perceived therapist efficacy and good-fit (Tinsley, Bowman and Barich, 1993; Digiuni, Jones and Camic, 2012) as well as previous helpful therapeutic experiences (Vogel, Wester, Wei et al., 2005). This was the experience of Pat, Ed, and Dani who all had previous helpful therapy and an understanding of what the process involved. However, after her first telephone contact with her therapist, Dani rapidly switched from a positive expectancy to doubt, and it took three sessions before Dani felt able to trust her therapist. These conflicting feelings of hope and doubt evident in my findings matched those of an early work by Fitts (1965) who found that uncertainty, conflict, fear and hope characterised early therapy, with fear and conflict often persisting throughout all of therapy. He also pointed out that "fear is one of the motivating factors that cause people to seek therapy – fear of what will happen without therapy" (Fitts, 1965, p.35). This was particularly evident in the accounts of Kira, Lisa and Tess, who each described the dilemma of further personal deterioration either with or without therapy. This finding also corroborates the theory that high levels of personal stress overcome negative transferences (Michal Schoenberg and Shoshana Shiloh, 2002) and corresponds with 'in-crisis' clients seeking psychological help when in desperation (Elton Wilson, 1996). On the other hand, Jane's continuing fears, her reluctance to engage in deeper exploration and early termination, could indicate that she was not psychologically ready to have psychotherapy at this point in her life. She may have been at the pre-contemplation / contemplation stages rather than at the action stage of therapy (Norcross, Krebs and Prochaska, 2011) indicating that she was a 'visitor' trying therapy out (Elton Wilson, 1996) and not ready for change at this time.

Although fear of stigma (Kushner and Sher, 1991) and fear of opening-up in therapy (Vogel and Wester, 2003; Hill, Satterwhite, Larrimore et al., 2012) have been well documented as avoidance factors that inhibit people from entering therapy, my findings challenge this notion. Participants did enter therapy holding these and other major fears. Research shows that prejudice, discrimination and negative judgements from others regarding mental illness and help-seeking can be internalised as personal inferiority, weakness and failure for needing professional help rather than managing on one's own or with help from family or friends. If public stigma becomes internalised as self-stigma this can prevent clients attending therapy, participating actively in treatment, and additionally is implicated in early terminations (Michal Schoenberg and Shoshana Shiloh, 2002; Vogel, Wade and Hackler, 2007; Vogel and Wade, 2009). Self-stigma was apparent in Jane's account and appears to have contributed to her early termination of therapy but not kept

her from seeking therapy in the first place.

Internalised cultural and gender-role scripts were also evident in my findings. Tom reported acute discomfort about seeking help as it transgressed the socially prescribed norms of masculinity. His account supports studies on help-seeking and masculinity ideologies whereby gender-role norms of self-reliance, self-sufficiency and strength are in conflict with seeking help (Mayer and Timms, 1970; Addis and Mahalik, 2003; Galdas, Cheater and Marshall, 2005; Vogel and Wade, 2009). Additionally, fears of being moulded, diagnosed or categorised into a prescribed model of behaviour by a therapist were expressed by both Tom and Mike. Mike's account also revealed underlying fears of dependency, but interestingly loss of control and dependency fears were not just a male preserve. Dani and Lisa also feared disempowerment and being shaped by their therapists.

Fears of being hurt or harmed by an unskilled therapist or through the therapeutic process also lurked underneath participants' hopes. Most interviewees expressed the belief that effective therapy would depend in part upon the therapist's skill and expertise. Other fears included the unpredictable nature of the therapeutic process itself, and fears of discovery about self and others. And whilst these fears were apparent prior to and in the early stages of therapy for some clients, for others their fears continued to be experienced throughout their course of therapy. Engaging in a relationship with a stranger and talking about intimate issues brought up fears of shame and embarrassment. Roza feared humiliation, whilst Lisa feared that her self-disclosures might trigger negative judgements from her therapist, and for Kira it was the fear of having to admit her major issues in life. Fears of shame, embarrassment and talking about emotionally distressing material have been documented as avoidant factors leading to negative attitudes towards therapy (Komiya, Good and Sherrod, 2000; Vogel and Wester, 2003). However, Roza's and Lisa's strong positive beliefs about the efficacy of therapy prevailed over their fears of embarrassment and shame, and enabled them to engage fully with therapy. Conversely, Tess, Dani and Pat reported that they did not find it difficult or embarrassing to disclose, but perhaps this was more to do with the nature of their particular issues or their normal coping styles. This connects with research showing that individual coping styles influence both men's and women's attitudes towards therapy and play an important part in therapeutic engagement (Beutler, Harwood, Kimpara et al., 2011), as those who talk to others about their problems generally held more positive attitudes towards therapy (Vogel and Wester, 2003). Another point to consider is that other socio-cultural elements were possibly involved as Tess, Dani and Pat were older, and perhaps more comfortable in talking about themselves, whereas Roza, Lisa and Kira were younger.

For many the fear of the unpredictability of the therapeutic process was evident, as well as how change would be manifested. Mike was sceptical of being offered a standard theoretical explanation by a stereotypical therapist as depicted in films and cartoons. These findings support research by Kushner and Sher (1991) who list embarrassment, change, scepticism, treatment stereotypes and talking about specific problems as issues which increase personal anxiety. They further add that fears are not static but can change throughout the therapeutic process. This was evident in both Jane's mounting anxiety when her therapist enquired into her family relationships and Lisa's new fear of losing her therapist's respectful empathy when she disclosed aspects of her behaviour.

It seems that, in order to seek treatment, people have to manage multi-faceted fears that are culturally and personally influenced, by weighing-up the costs and benefits of treatment. Costs include the perceived negative consequences of having therapy, such as mental and physical deterioration, time and finance which links with previous research (Kushner and Sher, 1991; Hill, Satterwhite, Larrimore et al., 2012). Both Jane and Tess were concerned with these costs. Tom and Lisa particularly feared being hurt or damaged by the process of therapy, and Kira, Rosa, Jane, Dani and Mike feared discovery either about themselves or their family, and the consequences arising from this.

Although mentioned, very little in extant literature illustrates in such nuanced descriptive detail the range of fears that clients have about therapy as my study has uncovered. Moreover my findings correspond with a growing body of research suggesting that, in order to be able to engage in therapy and talk intimately about themselves, clients needed to overcome their fears sufficiently. For many there was a conscious decision to risk opening up to self-exposure and vulnerability. For others like Kira, it happened spontaneously after some months of experiencing their therapist's consistent warmth and concern. Once they took the risk it opened the way to 'relational depth', described as moments of profound connection between client and therapist (McMillan and McLeod, 2006; Knox, Murphy, Wiggins et al., 2013). Research indicates that moments of relational depth are associated with positive therapeutic outcomes, and that both client and therapist factors are required in order to achieve this experience, although Cooper (2013) suggests that clients rather than therapists may be the determining factor as to whether these moments happen. This seems to challenge the theory that successful outcome depends upon the therapist's ability to form positive alliances with their clients and not on how well the client is able to form a relationship with their therapist (Baldwin, Wampold and Imel, 2007).

And yet whilst most interviewees managed to overcome their fears and engage fully in therapy, Ed felt disappointed by his therapists' coolness and reticence to provide psychological education.

Mike's defences undermined his ability to engage fully with therapy, and Jane's escalating fears caused her to end therapy early. These findings highlight how the complex dynamics of therapist skill, intra- and inter-subjectivities, as well as clients' readiness and stage of change all feature in whether a client can fully engage in therapy.

My findings also emphasise the importance of dealing with client fears, and correspond to Coren's (2001) proposition that in brief-term therapy addressing pre-transference fears in the initial session is a priority as these are "likely to be a reflection of the patient's core beliefs and fundamental anxieties" (p.117). Other clinicians express similar views: "If a client can be helped to express such fears early in the therapy, and if you [therapist] respond by recognizing them as valid, the therapeutic relationship can be saved" (DeYoung, 2003, p.67). Maroda also believes that for clients "the point of change occurs at the point of emotional surrender" (Maroda, 1998, p.63), alongside some degree of surrender on the part of the therapist.

In summary, my findings complement those from previous research indicating that practical and theoretical knowledge about the process and efficacy of therapy helps overcome the barriers that prevent people from seeking therapy, and additionally produces a positive transference towards the process. Yet the majority of my interviewees, and in particular those who were first-time clients, entered therapy holding multiple fears about the process and the therapeutic relationship. Explicitly attending to fears of therapy in the early sessions is thought to be a crucial intervention for alliance-building and successful outcome (Horvath, Del Re and Symonds, 2011) as unaddressed fears of the therapeutic process may not only increase negative feelings towards both therapy and the therapeutic relationship, but may also be implicated in client dissatisfaction, partial engagement and the early termination of therapy.

### **5.3 Clients' thoughts and feelings when first meeting their therapist**

A common fear expressed by my interviewees was whether they would get on with their therapist. Fears about interacting with a therapist may be connected to inherent temperament and personality (Kagan, 2011) as a recent study using the 5-factor model found that individuals who scored high on disagreeableness / antagonism showed scepticism and negativity towards therapy, whilst those with high agreeableness displayed optimistic attitudes towards therapy (Kakhnovets, 2011). However fear of interaction may also link to individual attachment styles. Hill et al (2012) found that those undergraduates with a secure attachment style not only had fewer fears about engagement with a therapist but held more positive attitudes about therapy than those

who were insecurely attached (Parish and Eagle, 2003). Interestingly, Mike, Kira and Jane each acknowledged their avoidant and ambivalent behaviours in therapy.

Neurobiological and developmental research indicates that humans process emotion, stress and non-verbal communications in their right brain hemispheres, and infants' right brains develop and are shaped by their social and regulatory interactions with others (Siegel, 1999; Schore, 2003; Gerhardt, 2004). The theory argues that, through repeated interactions with others, infants develop 'implicit relational knowing' i.e. unconscious ways-of-being-with another (Stern, Sander, Nahum et al., 1998). So when meeting a person for the first time the unconscious or out-of-awareness thoughts and feelings generated by implicit-procedural memory (Siegel, 1999) may be projected onto the other in what is known as transference.

In psychotherapy, these internal generalisations of previous interactions with authority figures and those in care-giving roles, as well as generalised expectations of the therapist's role and relational interaction, have been described as pre-transferences (Gelso and Carter, 1994). With my question as to interviewees' thoughts and feelings on first meeting their therapist, I hoped to elicit some of pre-transferences, transferences and countertransferences that were operating at the beginning of their therapeutic engagement. My findings demonstrate how positioning oneself with another was a dominant theme for many.

A positive transference seems to support and deepen the relationship, whereas a negative transference can have an adverse impact on the relationship and create ruptures. This was evident and made explicit in the interview process, particularly by Dani who emphasised the significant impact that first impressions have on a client; a finding that matches previous research showing that favourable first impressions benefit therapy (Manthei, 2006). These findings not only support transference theory and implicit ways of relating, but demonstrate that therapist warmth and friendliness can reduce fear and negative transferences as well as facilitating a positive transference.

The above finding also corroborates relationship research demonstrating that an embryonic therapeutic alliance, defined as a bond (Bordin, 1975;1994) can form and develop into a 'real relationship' in the first moments of therapy (Moore and Gelso, 2011). The real relationship "begins to develop from the moment the therapist and client first meet. In addition to their verbal exchanges, the participants' nonverbal exchanges - such as voice tone, eye contact, and the affective experience of each toward the other - are also contributory." This proposition is supported by neuroscientific evidence demonstrating that an ancestral social-neural system seems to be activated when people expect benefit from a ritualised healing experience, and that

humans quickly make judgements about the trustworthiness of their doctor/therapist based on facial expressions and non-verbal behaviour (Benedetti, 2011).

After the first contact with her therapist by phone, Dani's dislike of and doubts about getting on with her therapist were gradually soothed as Dani began to sense her therapist's empathy in session. Similarly an instant negative transference reaction was generated in Lisa when she found her therapist was male, but to her surprise, and unlike her previous relational interactions with men, Lisa experienced her male therapist as respectful and non-judgemental which in turn enabled her to trust him. These examples illustrate the existence of a dynamic intersubjective system between therapist and client co-created unconsciously from first contact in a continual reciprocal flow. Interestingly, the two therapists concerned implicitly repaired an initial rupture through their consistent empathic attunement (Beebe and Lachmann, 2002) without the problem being consciously discussed in session.

The empathic attuning process of being soothed and regulated by their therapists facilitated the switching of negative transferences to positive projections. This suggests that insecure attachment styles were transforming into secure attachment relating alongside a reduction in client fear, well illustrated by Roza and Kira who both described sensing their fear physically leaving their bodies. These examples also support rupture theory (Safran and Muran, 2006) that ruptures "are essentially transference-countertransference interactions" and can be repaired implicitly. They also corroborate intersubjectivity theory (Stolorow and Atwood, 1992) that empathic attunement can heal "the hurt child in the anxious adult" (DeYoung, 2003, p.36); and they uphold relational psychoanalytic theory (Mitchell, 2000) positing that the therapeutic relationship is continuously being negotiated between therapist and client on both conscious and unconscious levels.

Maternal transferences were particularly evident from my findings. Feelings of security, comfort and being attended to were explicitly expressed by my interviewees choosing objects and metaphors depicting the sun, warmth, playing, walking hand-in-hand and a mother figure. These feelings of nurturance and support are linked with therapist empathic attunement, and through being heard and understood sensitively and respectfully by the therapist. My findings complement psychoneurobiological and developmental theories that unconscious, subtle, deeply empathic attuned moments, as well as attachment and regulatory communications are operating between therapist and client through their non-verbal right-brain to right-brain interactions. These attuning interactions parallel the bonding and regulatory behaviours that mothers engage in with their infants (Bowlby, 1988; Siegel, 2006; Schore and Schore, 2007); and furthermore, appear to be a crucial factor in facilitating relational depth moments in therapy (Cooper, 2013). This

therapeutic relational configuration has also been termed the developmentally needed/reparative relationship (Clarkson, 1995) and reflects the strong developmental component in intersubjectivity theory (Stolorow and Atwood, 1992).

Tallman and Bohart (2008, p.102) suggest that clients are active change agents, each creating their own therapist and using the therapeutic relationship as a “safe, sheltered space” to strengthen their psychological selves and activate self-healing. My findings provide support for this hypothesis as some interviewees reported that, whilst they held some anxieties, nevertheless they actively sought a positive transference or schema to project onto their therapist and additionally, in our interview, Tom similarly projected his mother onto me. Like friendliness from a stranger, finding similarities helped reduce stranger-fear, enabling clients (and interviewees) to form a therapeutic alliance and bond quickly with their therapists.

In the past there has been much debate on what concepts constitute the alliance, but the revised alliance theory now emphasises “the active collaboration between the participants” (Horvath, Del Re and Symonds, 2011, p.27) that creates the therapeutic working space. “[t]he alliance represents an emergent quality of partnership and mutual collaboration between therapist and client ... its development can take different forms and may be achieved almost instantly or nurtured over a longer period of time” (Horvath, Del Re and Symonds, 2011, p.28). Evidence derived from meta-analyses indicates that positive alliances can happen within the first four sessions (Horvath & Symonds, 1991), whilst attachment needs at least five sessions to develop (Mallinckrodt, Porter and Kivlighan, 2005), with the client’s attachment style being modified by their transference. Roza, for example, described an evolving mutual relationship whereby she initially showed an anxious vigilance and only gradually, as the relationship developed, was she able to feel that a trusting bond had grown between them. Conversely, although Jane collaborated by talking in her sessions, thus forming an alliance, she did not actively bond with her therapist. Jane found her therapist’s silences unnerving and her questions and suggestions disturbing. Interestingly Jane did not select any object in the interview that had a maternal connection or representation.

In my findings Tom provided evidence of an eroticised transference that matches Mann’s (1997) theory of erotic transference. Although often considered a negative form of resistance in psychoanalysis, Mann conceptualises it as a transforming love that happens between mother and infant, lovers, and also between therapist and client indicating early dependency and nurturing needs and signifying “the patient’s deepest wish for growth ... [a] wish to be known and understood” (Mann, 1997, p.9). Not only did Tom experience erotic fantasies about his therapist that he had to address, but he had also felt like a child being nourished by the process. There



was also mention of a spiritual quality in their relationship that enhanced Tom's feelings of wholeness, desire for life and connection with others, indicating that a transpersonal dimension was evident. This connects with the idea that, for men, feelings of spirituality may be psychologically linked to eroticism and sexuality (Lapworth, 2011) and this may be an interesting concept for further exploration. Perhaps the feelings and sensations felt with reciprocated maternal transference captures that of a transpersonal moment of rapture, a "harmonious interpenetrating mix-up" (Balint, 1979, p.66) of feeling like a fish in the sea or a baby in a womb that may also have a gender/sexual orientation bias.

#### **5.4 Clients' descriptions of their therapeutic relationship as therapy progressed**

Most clients described an authentic warm, compassionate, nurturing, attuned therapist that generated feelings of safety and trust within themselves such that they could relinquish their fears and disclose their deeper issues. In particular they felt less isolated with their distress, feeling heard and fully understood non-judgementally. Their reflections were evidence that the Rogerian (Rogers, 1951) humanistic principles of empathy, non-judgemental listening and congruence were being communicated to them by the therapists. Clients' experiences were being fully understood by empathic therapists who were also sensing implicit meanings and unexpressed emotions in their sustained efforts to resonate with their clients emotionally and cognitively. "Empathy not only gives permission, but also provides active support for exploration [and] is sometimes crucial for therapeutic progress" (Elliott, Bohart, Watson et al., 2011, p.137), as exemplified by Dani who on the third session became aware of her therapist's empathic understanding. With this recognition Dani's defensiveness dissolved and a collaborative working relationship began.

There is robust evidence that "client-perceived empathy predicted outcome better than observer- or therapist-rated empathy" (Elliott, Bohart, Watson et al., 2011, p.135) and from my findings it was crucially important for clients to feel that their therapist's empathic attunement was authentic and sincere. Not wanting a robotic therapist, Lisa only relaxed when she felt that her therapist genuinely cared and wanted to know her. However, genuine empathy also requires fine-tune adjustment from therapists to adapt to individual client's needs and boundaries. For example, fragile or hostile clients may find empathy too intrusive and too directive (Elliott, Bohart, Watson et al., 2011). None of my interviewees actually reported feelings of intrusion and control although some had initially been fearful about therapist power and being controlled. Roza was relieved to find that her therapist allowed her the control to go at her own pace, while Lisa described her relationship more equally as a non-competitive tennis game. On the other hand, Ed felt that his

therapist was not empathic enough, being unable to satisfy his needs for more interaction and psychological insight. Ed experienced his therapist's stance as a barrier against developing a deeper connection and this resulted in a relational rupture.

Returning to the theory that clients are active in creating their own therapists (Tallman and Bohart, 2008) as those who are "more open to and able to communicate their inner experiencing will be easier to empathize with" (Elliott, Bohart, Watson et al., 2011, p.143), my findings support this and illustrate how clients influence therapist empathy through a mutual process of communication. Firstly, before clients can open up they need either to let go of their fears or override them. Having experienced her therapist's unceasing warmth and concern, Kira finally let go in an explosive catharsis, whilst Lisa overcame her fears by being brave and surrendering to the process. However, letting go was partly contingent on whether interviewees felt they had established a mutually trusting real relationship. For some clients like Jane this trust never developed, whilst for some like Dani, Lisa, Ed and Pat, trust was established relatively early on. Others gradually opened-up whilst scrutinising their therapist's reactions. Roza, for example, fearing humiliation, controlled the process and protected herself by being hypervigilant, imparting fragments of information whilst at the same time observing how these were received by her therapist.

Participant accounts demonstrate the active role taken by them in their ways-of-being with their therapist. Lisa described her therapeutic relationship as engagement in a non-competitive tennis game that both wanted to keep going. These reciprocal implicit and explicit communications that happen between therapist and client link with the ideas of 'I-thou' moments and dialogic communication (Buber, 1923; Hycner and Jacobs, 1995); and a "shared implicit relationship" of "now moments" (Stern, Sander, Nahum et al., 1998; Stern, 2004) wherein each person is impacted by the other and new possibilities of ways-of-being emerge in the intersubjective space for both client and therapist (Stolorow and Atwood, 1992). Participants found that they could bring previously buried thoughts and feelings into the therapeutic space. Pat, for example, acknowledged a change in her normal way-of-being-with-another. She not only felt safe to cry in her therapist's presence but she also found that she could talk frankly with someone for the first time in her life. Interestingly, in our interview, she was able to cry freely without embarrassment because the therapeutic experience had so changed her that she could now transfer her new behaviour into other situations.

Along with empathy, unconditional positive regard is another of Rogers' (1951) core conditions and this comprises respect, acceptance, affirmation, non-possessive warmth, friendliness, prizing and support. Research indicates that whilst positive regard appears to increase client agency,

self-actualisation, self-disclosure and self-belief in engaging in an effective relationship, successful outcomes occur only when clients can perceive therapist positive regard (Rogers, 1951; Farber and Doolin, 2011). Evidence of perceived positive regard was particularly communicated by Pat and Tom who felt validated and valued by their therapists.

However clients are also active in the way they impact therapists and elicit this positive regard. Those clients who are “warm, empathic, and disclosing are more easily liked and affirmed”, whilst those who are more difficult to engage with are “less likely to consistently evoke positive regard from their therapists” (Farber and Doolin, 2011, p.180-182). Kira, for example, was initially deliberately difficult, not answering questions and switching topics to confuse her therapist. It took months before Kira was able to receive and trust her therapist’s unconditional positive regard. Lisa, on the other hand, having conquered her earlier fears of trusting a man, then feared that her therapist would change in his respectful regard when she disclosed more shameful behaviours. Yet again she consciously chose to trust him and found acceptance, warmth and respect in return. This enabled her to bring her full self into therapy and reap the benefits.

The way clients relate to their therapists also links with individual attachment styles. Research shows that clients with secure attachment styles quickly form strong real relationships with their therapists, whereas clients holding negative transferences or those with an avoidant style of relating (fears of vulnerability and shame) form weaker real relationships. Interestingly, stronger attachments were found to occur with clients with anxious attachment styles (fears of rejection and abandonment) as these clients were more likely to show dependency and make more effort to please their therapists (Marmarosh, Gelso, Markin et al., 2009; Mallinckrodt, 2010; Moore et al., 2011). My findings challenge this hypothesis as both those with fears of vulnerability and shame and those with fears of rejection appeared to make very strong attachments with their therapists.

My findings also reveal the reciprocal / mutual, real relationship that was developing between a client and a warmly empathic and accepting therapist. Participants talked of their therapist being the right person for them. These feelings accord with the concept of ‘relational depth’ and the deep connection that clients felt they had with their therapist (Knox, Murphy, Wiggins et al., 2013). Most participants felt sad when therapy ended because it meant saying goodbye to a good friend with whom they felt deeply connected. Interestingly, this sadness did not stop Pat and Tom wanting to have another course of therapy to continue working on themselves. Perhaps they also wanted to have more of that deep connection, albeit knowing that it would be with a different therapist.

A third core condition of the humanistic approach (Rogers, 1951) is congruence and refers to the

therapist being real and genuine with judicious use of own self-disclosures. Congruence is both intrapersonal and interpersonal requiring skill and judgement that harmonises with the needs of different clients. By modelling self-experiencing, the therapist facilitates increased congruence, ownership of feelings, acceptance of and receptivity to experience as well as change in the client (Kolden, Klein, Chia-Chiang et al., 2011). Therapist congruence was evident in my study and appeared to be an active factor in deepening a two-way trust process. Pat and Roza, for example, valued their therapists being transparent and straight with them. And Roza particularly appreciated her therapist's occasional personal disclosures, feeling that without them she might not have revealed her more painful material. Small disclosures from therapists were seen by participants as increasing trust and reducing power differentials as they made the therapist more real, human and less of an expert.

Other self-disclosures were in the form of therapists' mental images and feelings. Both Tess and Ed described how their therapists picked out patterns in their narratives and reflected back things they had said. Tess's therapist also disclosed her mental images, encapsulating elements of Tess's narrative, which was a powerful experience for Tess. The interactive shared thinking between therapist and client facilitated deeper exploration, such as when Mike and his therapist wondered together about his feelings as a toddler in his particular context. The different perspectives offered by the therapists helped create new narratives, understandings and insight for the clients. Conversely when these self-disclosures did not happen, frustration emerged, as was the case with Ed who wanted more input from his therapist. As a result Ed felt disappointed that a deeper relational engagement was not achieved with his therapist. These findings match those from other studies indicating that therapist self-disclosure can equalise and normalise the relational dynamic by providing reassurance, additional insight and modelling; although some clients found that therapist disclosure led to confusion and negative transferences regarding boundaries (Knox, Hess, Petersen et al., 1997; Burkard, Knox, Groen et al., 2006). This suggests that therapists need to be judicious in their use of self-disclosure and only use it for the benefit of the client.

The limitation of extant process-outcome research is that it has not been able to show that empathy causes successful outcome, because empathy is not a single variable. Rather, empathy is a complex concept comprising many facets and interwoven with other facilitative interpersonal skills and processes such as unconditional positive regard and congruence. As described above, there is so much overlap with many interlinking processes operating both consciously and unconsciously between therapist and client that individual variables cannot be separated out. Furthermore each client who comes to therapy has a different relational way-of-being or attachment, depending on their past relational history and psychological readiness. Robust

evidence has consistently found that no one approach fits all (Norcross and Wampold, 2011), and my study illustrates how flexible and skilled therapists need to be in ways of engaging with clients, in order to achieve collaborative therapeutic relationships and beneficial outcomes.

## **5.5 Trust and Collaboration**

All therapeutic work needs to be collaborative requiring active engagement from both therapist and client, since research shows strong links between client-therapist goal consensus and successful outcome, as well as between collaboration and outcome (Tryon and Winograd, 2011). My findings not only complement this research but also extend it by demonstrating that there is more depth involved. Connected to the explicit processes of negotiating aims and collaborating in the work together, there are implicit processes operating synchronically since clients need to be able to trust their therapist's skill in mapping this uncharted territory as well as in keeping them safe. Lisa encapsulates this well. She described her very successful therapy as having both an agreed goal and an active collaborative relationship that attended to achieving her aims. Adding that she had to trust and rely on her therapist's skill to guide and manage the process well in order to keep it focused. This example also highlights the explicit and implicit nature of the collaborative engagement that also depended upon the therapist's "responsiveness" (Stiles, Honos-Webb and Surko, 1998) to what was happening overtly and intersubjectively in session.

My findings also illustrate that different clients want and need different things from their therapists and that collaboration and trust are also mutual processes of negotiation. Roza, for example, needed to be able to trust that her therapist could hold her and her painful disclosures without crumbling, and Dani was helped by her therapist to find the way through her problem herself rather than being given direct advice. When clients did not get what they wanted from their therapist or achieve their goals, they perceived their therapy to be unsuccessful. For example Jane wanted advice and reassurance rather than psychotherapy at that particular time and, in hindsight, Mike was disgruntled at not having established any particular goal to work on, Ed neither gained the psychological knowledge nor connection that he desired, and Tess felt disappointed at not reaching the heart of her problem. However, rather than explore, Tess seemed to have organised her therapist to collaborate on developing effective relaxation strategies that Tess could continue to use in everyday life to reduce her stress. These examples accord with studies showing that different clients need or want different things at different times (Cooper and McLeod, 2007) and secondly, emphasises that a flexible integrated therapeutic approach best meets these varying individual client needs and wants (Norcross, 2011).

## 5.6 Ruptures and Deference

Therapists also need to be “attuned to subtle indications of ruptures in the relationship and to take the initiative in exploring what is transpiring in the relationship when they suspect that a rupture has occurred ... to respond in an open or non defensive fashion, and to accept responsibility for their contribution to the interaction” (Safran, Muran and Eubanks-Carter, 2011, p.235). Jane’s account exemplifies how her unexpressed fear of and dissatisfaction with her therapist’s way of working created a relational rupture. Only when Jane’s therapist became aware of Jane’s frustration and raised the issue, inviting Jane to discuss her negativity about therapy, was the rupture resolved. Although unfortunately it was their last session, as Jane had decided to leave, it was cathartic for Jane as it enabled her to voice her anger for the first time. Research indicates that ruptures in therapy can also be repaired implicitly through the re-negotiation of the tasks and goals of treatment (Beutler, Harwood, Michelson et al., 2011; Swift, Callahan and Vollmer, 2011). Perhaps Jane’s early departure from therapy could have been avoided by changing therapeutic focus earlier in the therapeutic process and offering her a more supportive form of therapy.

In therapy there can also be “periods of ambivalence” (Mearns and Dryden, 1990, p.16) that may link with client dissatisfaction with therapy and/or the therapist and interfere with client engagement in therapy. This ambivalence occurred with Pat who at one time felt that therapy was not working for her; nevertheless she felt safe enough to express her anxious and doubtful feelings. Likewise Lisa felt brave enough to disclose everything even though she feared losing her therapist’s respect. These examples challenge Rennie’s (1994a) theory of client deference, that much emotional and mental activity is kept hidden whilst clients actively select what they communicate to their therapist. Various reasons are suggested for why clients do not disclose negativity: to make a good impression, to keep their therapist on side, to repair ruptures or in self-defence. Although this may be happening in many instances with all clients at certain times in therapy (Hill, Thompson, Cogar et al., 1993; Rennie, 1994a; Rennie, 1994c), perhaps in our current cultural climate, with media exposés and online social networking, people have become less deferential and reticent, and are now more able to speak out. Recent findings have found that young adults (18-20yrs) who had never been clients nevertheless expected to be able to discuss any conflicts arising in therapy with their therapist (Hill, Satterwhite, Larrimore et al., 2012), but as Hill’s study was small and these participants lacked actual client experience this remains conjecture. Important to note is that Rennie (1994a) also posits that it is up to the therapist to enquire about clients’ inner discomforts and discontent, and in the integrative training course practitioners are trained to encourage client disclosures of negative feelings about

therapist or therapy. This open and non-defensive attitude held by the integrative trainee practitioners concerned may have played a part in the way that Jane, Pat, and Lisa were able to reveal their negativity.

### **5.7 When therapy ‘takes’ – Judging success in terms of ongoing process**

John Rowan (1989) stated that: “[o]ne of the ways in which I recognise that success is on the way is when the therapy *takes*, in the sense that the person starts talking about how they thought more about what happened in the last session, or about how they have been recording their dreams and trying to work them out, or how they have been having insights between sessions. If this happens, it really seems to mean that success is on the way, and conversely.” (Mearns and Dryden, 1990, p.102)

My findings demonstrate that clients are also aware of these cognitive change factors. For example Dani described how the therapeutic process set her thinking in-between sessions such that she would take back her reflections to the following session. Mike and Tess reported sensing physical shifts through gaining insight from challenging questions, whilst Ed became adept at noticing his patterns and reflecting on them in a different way. Others found the alternative understandings and meanings offered by their therapists to be stimulating and insightful even when sometimes these new perspectives were painful to acknowledge. On the other hand Jane found that questions which offered new perspectives on her family exacerbated her anxiety and were not helpful.

Clients perceived emotional change in varying ways. For Kira it happened explosively when she dropped her defences and the work of therapy could begin, whereas Pat’s experience seemed more gradual. Through the process of connecting deeply with her unacknowledged feelings she discovered strength and understanding. Lisa and Roza also found empowerment in the understanding of how to process emotions as well as gaining more insight into their different emotions in and out of sessions. Indications of success in behavioural ways were reported by a number of interviewees. Lisa experimented with different behaviours outside of therapy to test herself; and Tom, Pat and Tess were also trying out new strategies and ways of being with self, others and the world. For Tess, insight came with the gradual realisation that she had choices. Tom became more energised and started to socialise again, while Pat’s increasing self-awareness and empowerment not only enabled her to relate to others in more helpful ways but also to become more mindful of the present moment.

And finally, many knew that therapy was successful when they began to feel physically and mentally lighter, calmer, balanced, more in control of their processes and generally feeling happier.

## **5.8. Symbolism and Metaphor**

As the interviews progressed all participants were able to recognise and acknowledge that different relational dynamics were operating between themselves and their therapists. It has been demonstrated above, firstly, how a maternal transference relationship evolves when clients are attended to and nurtured and, secondly, shown how the therapeutic relationship develops through a respectful two-way trust process that is occasionally tested. I would also like to illustrate the other relational dynamics that were formed between the interviewees and their therapists. The descriptions of these dynamics predominantly emerged from the process of selecting objects from the object-tray, and included terms such as: friend, helpful companion, teacher, guiding light, midwife, nurse, and fellow investigator alongside repeated symbolic themes of struggle, journeying, movement from down to up, from dark to light, as well as transformation. I discuss these findings within a metaphorical and symbolic context below.

Jung (1964) believed that “a symbol always stands for something more than its obvious and immediate meaning” (p.41) and that “whatever the unconscious may be, it is a natural phenomenon producing symbols that prove to be meaningful” (p.93). Jung adds that “part of the unconscious consists of a multitude of temporarily obscured thought, impressions, and images that, in spite of being lost, continue to influence our conscious minds” (p.18). Furthermore, “metaphors allow us to understand one domain of experience in terms of another” (Lakoff and Johnson, 1980, p.117). Holding these understandings about the unconscious and the power of metaphor, my study aimed to evoke hidden symbolism and metaphorical descriptions of the therapeutic relationship through the use of my object-tray.

Spatial metaphors were used by my interviewees to describe the process of therapy as a journey moving from one psychological space to another. For example both Dani and Lisa symbolised their desired transition with the use of a bridging agent - a ladder that would free them from being trapped in their hole and into more light. The ladder classically symbolises a breaking-through from one world to another, for example, from hell to earth (Cirlot, 2002); these findings agree with the argument that spatial orientations are grounded in our physical and cultural experiences such that we view happiness as ‘up’ and sadness as ‘down’ (Lakoff and Johnson, 1980).



Interviewees also anticipated and conceptualised hidden perils navigating this therapeutic journey. Holding a crocodile, Dani described it as a physical process of swimming down a dangerous river, while Lisa's metaphorical axe alluded to an irreversible experience with the possible consequences of destruction and restoration. In Lisa's mind her therapist ultimately held the power, like that of an axe, which could either destroy her or make her better. The axe can be a weapon as well as a useful tool in symbolist theory and signifies the power of celestial light as well as death. The axe also symbolises a labyrinth, a confusing maze which in Greek mythology could have a monster in the centre waiting to devour all who enter (Cirlot, 2002). Interestingly Lisa's account also captures this labyrinthine aspect of getting lost on a puzzling and dangerous journey with someone who could eat her alive if he wanted. Lisa's chosen monster (like Dani's) was the crocodile, which denotes fury, evil, vicious destructive power as well as fecundity, power, knowledge and rebirth. Selecting a tank and a gun to represent danger and war, Lisa also described how she had to battle with negative thoughts and feelings about her male therapist, whom she had depicted as her enemy. Symbolically, war denotes the struggle of light against darkness, good against evil (Cirlot, 2002).

Kira picked up the black cat from the object-tray to symbolise her furtive behaviour in therapy. Initially she depicted her therapist as easy prey, but gradually their roles switched and Kira felt she became the wounded lamb and her therapist a crocodile or lion. According to Jung, animals stand for subhuman instincts and unconscious areas of the psyche, and a black cat, because of its colour, symbolises darkness and death (Cirlot, 2002). This was Kira's mental state when starting therapy, but by the end of therapy Kira was transformed, describing her therapist as a sun and a friend while she, Kira, imagined herself walking along a new path in her life through a field of sunflowers. Sun symbols denote warmth, light, transparency, illumination, revealing of reality, spirituality and glory (Cirlot, 2002).

These ancient symbolic themes of death and life were also evident in the maternal transference process, but here there is more a feeling of regeneration. Tom initially conceptualised the therapeutic interaction as a Pandora's Box which is associated with human life, the unexpected and destructive unconscious, devastation and death (Cirlot, 2002). He also selected the heart and the arrow from the object tray to describe how his heart had been wounded in the past. The heart symbolises a life-force, happiness, love and illumination, whilst arrows signify supreme power. Additionally, an arrow has a phallic shape and so the heart being pierced by an arrow symbolises connection and unity (Cirlot, 2002) and Tom's erotic transference towards his therapist was transformed into self-rejuvenation and re-connection.

In other examples of maternal transference, Pat described paddling in a shallow river with very

clear, warm water and playing in the sun. Symbolically, water represents mother, baptism, annihilation, rebirth and regeneration, and the sun represents warmth, illumination, transparency, constancy, purification, spirituality, as well as vanity (Cirlot, 2002). Likewise Roza also described herself playing in the sun being watched metaphorically by mother, and combined this with the journey metaphor where mother then took her child's hand as they walked together.

This concept that therapy is a shared process with helpful collaboration from the therapist formed a significant and recurring theme. Rosa, continuing with the rebirthing/regeneration theme, described her therapist in medical terms, as a mid-wife accompanying her and helping her in giving birth to her thoughts. She also depicted her therapist as both a nurse and a syringe, injecting her with endorphins, drawing out her toxins, and giving her a voice. Similarly, Lisa conceptualised her therapist as an educator, skilled in assisting her to label her emotions accurately, and as a helper developing her awareness and strength.

Roza's therapist represented an older woman companion and wise guide showing her where to go in order to integrate her past. Holding the amethyst gem in her hand, Roza recounted that with her therapist's facilitation she had made valuable discoveries about herself that could be revealed rather than hidden behind the closed doors of her mental rooms; additionally she was able to lay her past to rest. Dani similarly described her therapist as a guiding light that spotlighted the area where Dani could go to find the key that would unlock Dani's buried processes and then together they were able to open and close doors. Lisa also felt that her therapist had helped her open the door to insight and self-knowledge. Doors allow access to hidden places and keys symbolise the mystery of a task that is about to be performed and the process involved; keys also mean the discovery of knowledge to unlock secret chambers of precious objects (Cirlot, 2002).

On the other hand, Ed felt that, although he had possibly found the key that would unlock his cage, he still did not know how to use the key in order to change. And Tess too was disappointed in not having found the key to release her from her locked cage. Many other interviewees also saw their therapists as being a light source that guided them and illuminated the way through by offering different perspectives, as well as focusing on and highlighting their unhelpful patterns, while Mike experienced his therapist as a co-investigator and someone who contained each session and kept it useful.

## **5.9. Methodological Aspects for Discussion**

### **5.9.1 The impact of my enquiry method**

Jung described how unconscious perception through our senses can cue or trigger forgotten memories and images or ideas that can be “moved back from the unconscious into the conscious mind” (Jung, 1964, p.24) and, to an extent, this was achieved through the provision of my object-tray. As my aim was to elicit deeper level thoughts that captured my interviewees’ therapeutic experience, I found that having objects worked extraordinarily well in stimulating their thinking processes. It proved to be a powerful method that facilitated the encapsulation of complicated feelings and thoughts that could be imparted in a way that reached the essential core of the experience. The variety of objects helped clients describe their experiences metaphorically and symbolically, and the evocation of out-of-awareness thoughts was evident when interviewees were occasionally surprised both at the objects they selected and at what emerged between us in the interview process. It was also interesting to observe how my interviewees selected their objects and what they did with them in the interviews; furthermore, to discover later how their objects and metaphors significantly linked with universal and historic symbolic theory.

Although everyone seemed to uncover meanings and thoughts that came from deeper layers of consciousness by using objects, describing the relationship they had with their therapist was generally not easy for them. And sometimes there was not an object on the tray that worked for them. When I noticed this difficulty I would ask participants how they would paint their relationship instead. This activated the imaginative process and rich dynamic images emerged. A good example comes from Kira (see 3.1) who recounted how she controlled her therapy for the first four months. Having chosen the black cat to depict herself, I helped Kira think about her therapeutic relationship by inviting her to imagine painting her therapist and then to imagine an animal that would portray her therapist, thereby describing a relationship.

Participants sometimes took their time in selecting objects, whilst at other times they reached out and picked up one or more objects instantaneously. An example of this and how the objects were handled comes from Tom (see 3.1) who, having selected three items, talked about each in turn until he was left with the snake that encapsulated the principal issue that he brought to therapy. In their recent paper, Hill et al (2012) highlighted the difficulty for participants to identify and describe their attitudes and beliefs about therapy as such information is often implicit. My object-

tray method was used to circumvent just this sort of difficulty. Cognitions, feelings and different relational dynamics were uncovered by this process and expressed in rich and vivid detail, often with a sense of surprise and recognition. Meanings and thoughts appeared to be triggered subliminally, as 'unthought knowns' (Bollas, 1987) rather than consciously considered. Furthermore, the object-tray introduced an element of play and creativity into the interview process that invited metaphorical thinking and seemed to encourage different perspectives and ways of understanding the therapeutic process.

### 5.9.2 The impact of the research relationship

As a relational therapist I recognise that the interview encounter has parallels with the therapeutic encounter in that knowledge emerges from the dialogical meeting of two people interacting in a focused task with both conscious and unconscious processes operating intersubjectively (Finlay and Evans, 2009). As a reflexive practitioner I am also aware that reciprocal changes happen through the embodied intersubjective experience, and consequently the person I was as an interviewer/researcher would have an impact on the kind of data that would develop between us (Etherington, 2004). To reduce power differentials and in order to obtain the best possible data I felt it important to be welcoming, friendly, helpful and sensitive to my interviewees' states of mind throughout the interview process, aiming to provide an atmosphere that I hoped would enable them to relax and enjoy the 'play' element of the object-tray. Influenced by my counselling and psychotherapy training I also wanted to provide a safe space for exploration (Bowlby, 1999) that would also be supportive and containing should painful emotions be triggered within the interviewee during the interview process. Transferring my practitioner skills to my role as a researcher I tried to be aware of both my own changing emotional processes as I interacted with each interviewee as well as my impact on the process.

Elliott and James (1989) posited that clients may not give truthful accounts, either by deliberately or unconsciously limiting or distorting information given to the researcher. This may well be true at times and yet I was struck by the apparent openness and honesty of my interviewees, particularly when they expressed the problematic aspects of their therapeutic experience. Their candour was particularly evident in their obvious reluctance and hesitancy when they became uncertain about telling me something, for example, in revealing their thoughts about their therapist. At these moments I became internally excited at the prospect of obtaining data that provided negative elements because, not wishing my research to have a totally positive bias, I was looking for complexity and richness. Negative comments and nuanced statements

contributed not only to the veracity of interviewees' accounts but overall to the validity of my research.

For example, although Dani became hesitant about revealing her initial negative thoughts about her therapist, my friendly and welcoming approach impacted her and enabled her to disclose her truth. Jane (see 3.1) also stated that my non-verbal behaviours and facial expressions had conveyed my understanding of her feelings. This implicit compassionate communication from me had facilitated her to talk about her problematic therapeutic experience and she reported that the interview process had brought her closure.

Although all my participants were white, middle-class Europeans from five different countries, the majority were British and the sample comprised seven women and three men. My being white and British meant that there was an immediate similarity between us. As I was both older than most of my interviewees and a qualified psychotherapist, this positioning helped me to manage my anxieties about interviewing people for the first time as a researcher. For two of my participants English was not their first language, but from our initial conversation on the phone I ascertained that their English was certainly good enough. Having experienced living with a parent for whom English was not a first language, I felt confident that I could communicate with the two non-English interviewees. I considered that the use of an object-tray would be an efficient aid to encourage metaphorical thinking as well as word recovery. Furthermore, I felt that the addition of a few cultural metaphors would increase the richness of my data.

Roza (see 3.1) for example, could not see an object on the tray that described her experience. However, through her descriptive imagery and demonstration, along with my help in supplying appropriate words, we arrived at a symbolic representation of the collaborative relationship she had with her therapist and the way they gained understanding and insight, as well as uncovering her thoughts and anxieties about her sessions.

There were also times when interviewees became emotional remembering past painful experiences, and I was sensitive and respectful to what was going on for them in the present moment. I stayed with them mentally and waited until the tearful moment passed, taking my timing from them, offering tissues and checking that they felt alright to continue. My voice changed too during these moments, becoming softer and more soothing. This was a fine boundary to negotiate as I wanted to convey my empathic understanding but, unlike a therapist, I did not want to deepen their emotional processes. Yet as a researcher I hoped that, should my participants become emotional, they would also be able to recover and continue with the interview.

As an example, having selected a gun and a cage, Lisa (See 3.1) became tearful when talking about the gun's significance, and I had to judge whether to continue with that line of enquiry or not. As it related to her state of mind before entering therapy, I considered that there was no need to delve further as this was not part of my research. However, when a similar moment happened again, later in the interview, I had changed. This time I felt more confident in trusting that Lisa could manage her emotions when painful memories were triggered and that she would continue to participate in the interview.

The above examples describe some of the co-created relationships that developed between my interviewees and myself and demonstrate the emotional reciprocity flowing between us and how that mutuality impacted the interview process. They also demonstrate how psychological depth works on both implicit and explicit levels in all intersubjective activities. No doubt another researcher might have responded differently in the interview process, perhaps drawing out different data with correspondingly different considerations.

### **Brief-term versus long-term therapy**

I decided upon researching brief-term therapy because of the demand for this type of work in current society and especially because CBT is favoured over all other psychotherapies due to its large evidence base. In my study I was interested in discovering how many clients experienced improvement after a few weeks of integrative therapy and to elicit descriptions of their improved well-being. The therapy provided would have been up to 24 weeks with a proviso that, if either the client or therapist felt this to be too long, then an earlier ending could be arranged between them.

CBT practitioners work in a structured and directive way towards symptom reduction primarily by developing behavioural strategies to counteract early social conditioning, but my study illustrated how the reduction of anxiety and depressive symptoms happened as a by-product rather than as being the focus of the treatment. The integrative approach focuses holistically on addressing clients' mental states and explores deeply to uncover the reasons underlying their distress. As I did not interview the therapists involved, I do not know whether they altered their approach specifically for brief-term work, and maybe more research into this area would clarify this.

Another aspect that needs highlighting was that, for those who stated a slight disappointment with their therapy, such as Mike, Tess, Ed and Jane, they either had no particular goal to work towards, their therapist didn't engage in psycho-education or, in Jane's case, the line of enquiry her therapist tried to pursue was unhelpful. My conclusion from the data is that for brief-term work

it is crucial to be focused, have agreement on specified aims and goals, and to gain regular feedback from clients as to what is helpful/unhelpful to their needs and wants (Elton Wilson, 1996; Coren, 2001).

### **Ethical and practical difficulties**

Although asking clients about their therapeutic experience seems an obvious focus for research, it is fraught with ethical and practical difficulties. In order to find a homogenous sample of ex-clients I had to invite trainee therapists from one counselling agency to participate in my research. Their role was to hand my information sheet to their client at the end of their final therapy session. To the practitioners concerned this could be seen as threatening, as they were in training. To counter this issue I particularly highlighted to both practitioners and interviewees that the focus of the research interview was on the experience of the client and not about client judgement on whether the therapist had been good or bad. Only one therapist explicitly declined to participate in my research.

The boundaried nature of therapy means that, although therapists hold client confidentiality, clients are not bound by this same principle, but a few clients expressed concern in talking about their therapist. To facilitate a sense of comfort around this issue, I mentioned that there was no necessity to reveal their therapist's name, that it would not get back to them directly and, if they ever read this study, they would by then be senior therapists.

As it took over a year for ten ex-clients to volunteer, there may have been practitioners who forgot or preferred not to pass on my research sheet to their clients for whatever reason. This I will never know. However, every few months I emailed all participating therapists reminding them that I still required ex-clients, as well as thanking them for their continuing interest and help in my research. When I obtained my ten volunteer ex-clients I emailed the practitioners again to let them know that their participation was now concluded, to advise them that I would collect any remaining information sheets, to thank them again for their interest and support, and to wish them well in their continuing studies and professional life.

Recognising my duty of care towards these participant trainees as well as their ex-clients, when writing up my research I was aware of the power I had as a researcher in how I represented everyone concerned and interpreted their stories (Etherington, 2007). I also had to balance my own needs as well as use my material appropriately, judiciously and respectfully. Additionally, by being reflexive, I was neutralising the power imbalance by losing my authority status, and in my

self-disclosures I was also exposing myself and making myself vulnerable to criticism from others (Etherington, 2007).

Interviewees self-selected having been initially invited by my information sheet, and most reported that they felt drawn to participate because of their interest in psychology and counselling, as well as for altruistic reasons to help others.

Having already addressed clients' truthfulness in interviews (above), inaccuracy is another criticism of using clients' retrospective accounts, as important aspects may be forgotten (Elliott et al., 1989). However this criticism can be levelled at any method used to obtain human verbal or written responses, such as questionnaires or self-report measures. Nevertheless, to reduce memory loss, I set a limit of three months between participants having ended therapy and being interviewed. Whilst the majority of interviewees had their interview two weeks after ending therapy, there were two who came eight weeks after ending therapy and they also appeared to have no difficulty in recall.

Having found no difference or difficulty in my participants' recall, and reflecting on research findings that clients could accurately recall important events six months after counselling (Martin and Stelmaczek, 1988), I wondered whether coming for an interview after two weeks of ending therapy was, in fact, the best practice. Clients had presented with a mixed-range of problems: suicidal ideation, complex bereavement, depression, anxiety, relationship difficulties, anger, low self-esteem, alcohol issues, and life-transition dilemmas although they were, nevertheless, competent individuals. Yet two weeks after ending therapy some interviewees seemed to be still assimilating their therapy. Perhaps it would have been more advantageous to have waited and interviewed them between four to eight weeks of having ended therapy as, by that time, they would have had more time to integrate and reflect upon their experience. It is difficult to know and may depend on individual differences as well as the severity of their presentation.

Having an interview of 1.5 hours was a practical measure and did not feel too long. There was adequate time to settle clients, introduce my research, explain the ideas behind the object-tray and, most importantly, to be able to enquire deeply into my interviewees' experiences of therapy, as well as have a debriefing afterwards. During interviews I asked clients to reflect on their feelings regarding the start of therapy and on first meeting their therapist as they were at that time but, concerning the therapeutic relationship and their experience of therapy, their reflections were in retrospect.



Another ethical concern was that sensitive topics could trigger emotional distress in interviewees although, when this happened, I found that each interviewee could manage their distress, was happy to continue and subsequently reported finding the interview process beneficial. This accords with research indicating that experiencing distress in research interviews is transitory, understandable, non-harmful and moreover not regretted (Draucker, Martsolf and Poole, 2009). Furthermore, experiencing emotional distress that is safely contained by the researcher is considered helpful and augments the therapeutic experience of the interview process (Lakeman, McAndrew, MacGabhann et al., 2012). These findings add weight to previous studies indicating that research with ex-clients can be a beneficial activity for them not only in increasing well-being through being altruistic, but that the interview process is frequently therapeutic for them provided that participants are treated with respect and any emotional expression is contained safely (Manthei, 2006; Lakeman et al., 2012).

In summary, interview participation can be a celebration and extension of the therapeutic process (Etherington, 2001). My interviewees all felt that the interview process had been therapeutic, not only through being heard and understood but through acquiring an increased understanding of their experience by meaningful constructions and different perspectives. The process also brought a satisfying closure to their therapeutic experience. In qualitative research it is standard practice to stay in touch with interviewees throughout the process and to send them their interview transcripts for approval, amendments or comments. Only one of the ten interviewees refused this offer without giving a reason. Throughout the process, whenever we communicated, each expressed continued interest, was happy with the selected quotations and extracts and wished me well with completing my research.

### **Limitations, future research and implications**

As IPA is an interpretative approach it inevitably has researcher bias, although this has been moderated through supervisory checks and peer audit and validation throughout the process. In using global retrospective client accounts one loses the minutiae of unfolding active experiences, although one gains an understanding of the totality of clients' subjective experiences and links between events. It is also unknown how therapist inexperience may have contributed to these findings. The interviewees' therapists comprised two different male and six different female practitioners; one female practitioner had been the therapist for three interviewees. All practitioners during this time were either on a post-graduate Masters or Doctoral integrative training course in counselling and psychotherapy and in regular supervision with an experienced integrative supervisor. However, as they were not fully-qualified therapists they may not have

been as relaxed and flexible towards client needs and wants as more experienced therapists might have been in similar circumstances. Nevertheless it is established practice in low-cost counselling agencies to have trainees as practitioners.

Although there was a wide age-range (27-58 years) across interviewee participants, the number of interviews (10) was small, with women outnumbering the men (7:3). As my sample comprised white Europeans my findings might not apply to other counselling agencies with different cultural/racial/ethnic or clinical populations. People from other cultural/racial/ethnic traditions or clinical populations may have different expectancies, fears, metaphors and styles of relating, and it may be fruitful to obtain data from these different client populations to challenge our assumptions and augment our conceptions. Research could be carried out on homogenous groups in other counselling agencies and my object-tray method may have a particular advantage when conducting interviews, for example, with trauma sufferers or with those who find it difficult to articulate their thoughts and perceptions. Data can then feed into a practice-research network, thereby expanding the regional, national or global data-base of research in this area, providing practical guidance for therapists, making therapy more effective (Fenton, Harvey, Griffiths et al., 2001; Parry, Castonguay, Borkovec et al., 2010; Butler and Harris, 2012; Stratton and McDonnell, 2012).

Furthermore, regarding sampling, my findings only hold for those who stay in therapy. Interviewing clients with unplanned endings, early terminations or clients who dropped out of therapy would deliver a different study with potentially different findings.

### **Implications for training, clinical practice and services**

As this study was located in a naturalistic clinical setting with clients from the local population self-selecting to have brief psychotherapy, I consider that the potential impact of my findings may be to contribute knowledge in a variety of areas. It could inform NHS commissioners and IAPT (Improving Access to Psychological Therapies) about the complex psychological processes that underlie and influence the intersubjective human behaviours in therapy. It could also potentially help us to understand the reasons for drop-outs which could impact services and practices, since this project has really highlighted the fears that clients have at the start of therapy. It will also contribute clinical, practical and experiential knowledge that has interest to practitioners as well as to assessors, supervisors, and training institutions. For example, assessors could explore, particularly with first-time clients, their expectations about therapy and explain what therapy is about. This would help to demystify the therapeutic process, as well as diminish fears and

unrealistic expectations. Assessors could also inform clients about the importance of a collaborative therapeutic relationship, advise them how their role as client is to be open with their therapist, and that an appropriate and important aspect of therapy is to feedback to their therapist any concerns about therapy or the therapist's approach. This would empower clients to feel able to express their particular wants and needs.

As fear is such a normal part of the therapeutic process, this has implications for clinical practice, training and supervision. My findings show that clients are active in their therapy, and only when the client has relinquished their fears can relational depth be reached and the collaborative work of therapy begin. This indicates that therapists need to attend to client fears early on in therapy, and that perhaps client anxieties also need to be included in the therapist's formulation. This is important as not only may trainees be fearful of performing this task of surfacing fears but they may also be involved in a parallel process with their clients' fears at the start of therapy that could potentially lead to avoidance and splitting. Perhaps this needs to be addressed early on in training as well.

Novice psychotherapists may perhaps also benefit from more focused skills-training in brief-term work, especially in the establishing of client goals as well as asking for client feedback early on and continually throughout therapy. From my findings there was also a sense that therapists need to monitor their way of working continually, and if necessary specifically adapt their approach to what best suits their client so that their client has an involved and empowering therapeutic experience. Trainers therefore need to help trainees to adopt a responsive and flexible way of being with their clients, as extant client evidence indicates that poorly timed interventions and interpretations plus a rigid adherence to a technique or approach can impede progress, cause ruptures and can leave the therapist feeling frustrated and self-critical (De Stefano, Mann-Feder and Gazzola, 2010). Training that helps practitioners to feel confident in these areas will assist them to relate more compassionately with ambivalent and resisting clients.

My findings therefore complement the theories positing that the quality of the therapeutic relationship is paramount, and that therapeutic change appears to happen through the strength of the trust and the collaborative nature of the relationship as well as the flexibility of the therapist to adapt practice to individual requirements (Cooper and McLeod, 2007; Norcross, 2011). In psychotherapy research, increasing client motivation, involvement and reducing resistance and defence has been a continuing interest (Mahalik, 1994; Hill, 2005; Kelly and Yuan, 2009). My study has demonstrated that a good first contact maintains initial positive attitudes or pre-transferences that aid the therapeutic bond-forming process. This is something that therapists should hold in mind, particularly as an unfavourable first contact can set up negative

transferences within clients. When clients feel safe, with some control, and feel understood and trusted by their therapist, they feel more able to disclose difficult material, and even negative feelings about their therapy. Findings also highlighted how the dynamic two-way trust between therapist and client can be enhanced with therapist's small self-disclosures both on conscious and unconscious levels.

Another method of reducing client fears about therapy is by educating potential clients and members of the public about the nature of psychotherapy and how to make the best use of it (Spinelli, 1994). There seems to be a need to frame therapy as a healthy, positive, rewarding, empowering process rather than a weakness, explain how problems are often reversible and emphasise the professionalism of therapists (Corrigan, 2004; Vogel et al., 2009; Hill et al., 2012). By targeting different groups individually (e.g. women, men, young adults and separate cultural/racial groups, insecurely-attached individuals, lower educational groups) negative cultural attitudes, social stigma and myths can be overcome, symptoms can be normalised and social constructs of mental illness can be challenged.

As with the traditional humanistic-phenomenological and psychodynamic psychotherapies, my study offers a different discourse to describe outcome. Perhaps we could conceptualise change differently, not in terms of reduced symptoms as in the medical model (Larsson, Brooks and Loewenthal, 2012; Risq, 2013) but rather in linguistic terms relating to individual growth. For example therapeutic change can be described in terms of new, more helpful ways of being with self, others and the world. All these achievements increase personal well-being and, in the process, symptoms are reduced. And for those who criticise therapy as unscientific, the crucial question is whether therapy "achieves its claims of reducing or removing a great deal of psychic disturbance, misery and pain." (Spinelli, 1994, p.39). My study complements and adds support to the extant psychological, neuroscientific and psychotherapeutic research demonstrating that, for these participants, therapy did indeed achieve this claim.

Regarding the actual impact of my project, it has already influenced my practice. I have been more specific in my professional profile about the roles of client and therapist and what to expect in therapy. I raise the issue of client fears in assessment sessions and surface them whenever I become aware of them in the work. And I am increasingly monitoring our relationship and ways of working so that it best meets clients' needs and wants. For dissemination, I presented my findings at last year's UKCP conference and have further presentations planned this year, as well as submitting a research paper. I have presented my research to colleagues and assessors and discussed it in peer supervision groups as a more focused way of approaching our brief-term work. I have also had conversations with the clinical head of the counselling service about how it

might impact the assessments. I am also thinking about writing a book using my participants' accounts of their experiences in therapy, that will not only inform members of public about the psychotherapeutic process but will also help to reduce the fear and stigma around having psychotherapy.

## **Conclusion**

Our clinical work starts with our clients, their concerns and their well-being and we need feedback from our clients not only to maintain this commitment but also to hone our interventions and clinical practice based on their experiences. A test of a study's validity is whether it is plausible, useful and offers new ways of understanding (Yardley, 2000). I believe that my work will add to the evidence base of psychotherapeutic research and make a contribution to clinical practice and training by informing therapists, assessors, supervisors and tutors as to how clients perceive their therapy and the therapeutic relationship. Any shortcomings or problematic areas found can then be addressed in therapist training. My study also provides an innovative method of data-collection that can be used with other sample groups.

My evidence, drawn from the client's perspective, was found to deepen, expand and test current theory and research on psychotherapy and the therapeutic relationship. It vividly illustrates clients' active contributions and demonstrates some of the complexity of the therapeutic processes on both conscious and subconscious levels. It also details clients' multi-faceted fears and thoughts and reveals how these relate to client negativity, defensiveness and resistance.

Additionally, my study demonstrates that interviewees' descriptions of their psychotherapy closely fit with an integrative approach rather than any one single method or technique. These findings accord with current thinking that therapists need to be flexible in adapting to individual needs and wants. This research also offers an alternative way of describing client change that differs from the medical model of symptom reduction terminology.

Finally, my study challenges the arguments against using clients' accounts. I found that my participants were psychologically aware, and the objects facilitated recall, articulation and expression of perceptions beyond the superficial. Additionally, participants managed their emotional states well during the interviews, reporting not only that they found the interview process therapeutic but that it brought closure to their psychotherapy. They also expressed their interest and pleasure in being involved with a research project that would benefit others.

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**Study Title:** *What happens to psychological depth in brief term therapy?* Or more simply, what are the thoughts and feelings that clients bring to their therapy?

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

### **What is the purpose of the study?**

This study is to collect information directly from clients about their feelings and thoughts about their therapy and the therapeutic relationship.

The aim of this research is to pass on knowledge to practitioners, supervisors and assessors in this field so that they can have a better idea of how and what clients think about therapy.

The study will possibly continue into 2012.

### **Why have I been chosen?**

You have been chosen because you have undergone a course of therapy and ended a contract having completed a minimum of 6 sessions and up to a maximum of 24 weeks. I am looking for 10 participants to take part.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and at a later date, be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

### **What will happen to me if I take part?**

We will arrange a convenient time for you to come and be interviewed by me at Metanoia Institute and this interview will last one and a half hours approximately. There will be no questions asked about the issues you brought to your therapy. In fact it will be a completely different experience from your therapy as the focus will be on your perceptions, thoughts, images and expectations about your therapy and the therapeutic relationship. As a memory aid you will be asked to select objects from a collection of items for us to discuss.



This interview will be recorded and subsequently transcribed by me. At this stage there might be a necessity for me to contact you if there is anything that needs more detail or clarification.

After the analysis stage I will contact you and send you my analysis of your interview contributions, firstly for your comments and secondly for your permission to use this material. I will be looking at themes and categories connected with your thoughts and images and eventually combine this with contributions from the other participants.

### **Will my taking part in this study be kept confidential?**

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address *removed* so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation of the UK and all material will be destroyed after completion of my research.

### **What will happen to the results of the research study?**

The research will be published as part of a postgraduate dissertation in 2011/2012, and a copy will be held both in the library at Metanoia and also in the British Library if you wish to read it. You will not be identified in any report or publication.

If I decide to publish in an academic journal or at a conference at a later date then I will contact you again for permission and give you the opportunity to review the paper in advance.

### **What are the possible disadvantages and risks of taking part?**

I do not foresee any disadvantages or risks in taking part in this study. We will have a debriefing after the interview but if you feel that as a result of taking part in this research you would like further therapy then this can be arranged through the MCPS assessment procedure.

### **What are the possible benefits of taking part?**

I hope that participating in the study will be of benefit to you through increased self-awareness. It may also be insightful and possibly fun in a creative and collaborative way. However, this cannot be guaranteed.

The information received from your participation in this study will inform practitioners, supervisors and assessors working in this field so that they can have a better idea of how and what clients think and feel about therapy.

## **Who has reviewed the study?**

Metanoia Research Ethics Committee.

Metanoia Institute  
13 North Common Road  
Ealing W5 2QB Tel: 020 8579 2505

## **What do I have to do to take part in this study?**

Write your name and contact telephone number on the slip of paper found inside the envelope and seal it in the addressed envelope. Hand this envelope into reception or alternatively you can take this information sheet away with you and post it to me at a later date.

On receiving your communication, I will then contact you for any further discussion about the research and answer any questions that you may have. If you decide to take part we will then arrange an interview date and time.

On meeting we will both sign two consent forms so that we each have a copy.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

## **Contact for further information**

Magda Evans  
Researcher

Metanoia Institute  
13 North Common Road  
Ealing W5 2QB

Tel: 020 8579 2505

Dr. Biljana Van Rijn  
Research Supervisor

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Email: [Biljana.VanRijn@metanoia.ac.uk](mailto:Biljana.VanRijn@metanoia.ac.uk)

Thank you for reading this information sheet.

Participant Identification Number:

**Title:** What happens to psychological depth in brief term therapy?

**Researcher:** Magda Evans

Initial the boxes

I confirm that I have read and understand the information sheet for.  
the above study and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to.  
withdraw at any time, without giving any reason and that this will be  
done by letter or email. If I choose to withdraw, I can decide what  
happens to any data I have provided.

☐

I can decline to answer questions but if I decline to answer too many  
questions it may lead to termination of my participation

☐

I understand that my interview will be taped and subsequently  
transcribed

☐

I agree to take part in the above study.

☐

I agree that this form that bears my name and signature may be  
seen by a designated auditor.

☐

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

1 copy for participant; 1 copy for researcher

## Appendix 3

### The Object-tray

## The Object-tray

These are the objects grouped together in a similar fashion for each interview



## Appendix 4

## Demographics of participants

Name	Gender & Age	No of sessions of therapy	Previous therapy or first time	Satisfaction on ending	No. of weeks between therapy end and interview
Mike	Male 40yr	24	1st time	Good & wanted to continue	2
Tom	Male 53yr	24	Grp. & few wks of individual	Good & wanted to continue	2
Ed	Male 45yr	22	Few wks of previous different location 6m ago	Enough though disappointed	2
Jane	Female 27yrs	8	A few wks of CBT previously.	Enough though disappointed	4
Roza	Female 32yrs	24	1st time	Very satisfied	4
Tess	Female 49yrs	24	1st time	Very satisfied	2
Dani	Female 43yrs	12	2nd. 1st= few wks at same location	Very satisfied	11
Lisa	Female 31yrs	13	1st time	Very satisfied	4
Pat	Female 58yrs	20	2nd. 1st = 40wks	Good & wanted to continue	4
Kira	Female 30yrs	24	Had 3 wks of previous	Good & wanted to continue	5

- Anonymity protected – any extracts -> professional & academic forum
- Right to withdraw at any time during the process of the research
- Research is about your thoughts & feelings about your therapy & the relationship you had with your therapist

This type of interview is rather like a one-sided conversation and some of the questions that I ask may seem self-evident or repetitive but this is because I'm trying to get to grips about how you understand things. This adds detail and depth to your information. Please feel free to take your time in thinking and talking about the questions.

This is important as part of the interview process will be to select objects that you're drawn to from the tray. I'll invite you to pick up objects at various times during and try and select the objects using your gut-feeling rather than your intellect. Just select those that you're drawn to without any thought.

Sometimes I will be jotting down notes about your objects or aspects of your narrative that I may want to return to.

**1. What thoughts and feelings did you have before you came to therapy?**

Prompts: Hopes, expectations, fears. Fantasies. Dreams. Counter-metaphor. Meanings.

**2. What thoughts and feelings did you have when you met your therapist for the first time?**

Prompts: e.g. film/tv character, cartoon, animal, plant. Initial reactions.

**3. How would you describe your relationship with your therapist as therapy progressed?**

Prompts: Thoughts. Feelings. Behaviours. Relationship-changes?

Self- changes? Significant aspects? Difficulties/Uncomfortable moments?

Debriefing:

Recap & Review objects chosen & meanings? Any surprises?

- How did you find the interview process?
- Did you find it difficult to answer any of these questions? Which ones? Why?
- What was it about my research that drew you to volunteer?
- Further counselling
- Any questions for me?
- What happens next in the research process & further contact

Inconsistencies – "That's interesting. It sounds like you have several different kinds of feelings about.....

Can you tell me more about that? Expand on that?

How? What? Why? What if? Is there anything else?

Objects: You picked up. . .What does that mean to you? How does it speak to you from the inside?



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Magda Evans  
DCPsych programme  
Metanoia Institute

10<sup>th</sup> May 2010

Dear Magda

RE: *What Happens to Psychological Depth in Brief Term Therapy?* (ref: 4/09-10)

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as Chair of the Research Ethics Committee.

Yours sincerely,



Dr Patricia Moran  
Chair of Metanoia Research Ethics Committee

## Appendix 7

## A Section of Roza's transcript showing codings and emergent themes

ROZA	Line	TRANSCRIPT		Descriptives and in-vivo' quotes	Emergent Themes	Superordinates
English not her first language		<b>Interviewer's interventions are in bold</b>				
<b>Codings:</b> Descriptives - Normal type						
Linguistics - <i>Italics</i>						
Concepts - <u>Underlined</u>						
	104	<b>So in terms of therapy what...?</b>				
emotions at work -> emotions in therapy	105	It was a part of therapy talking about my work because obviously I'm in it all the time.		talking about work issues	Feeling heard & understood	Feeling heard & understood
	106	<b>Yes.</b>				
Feelings (-ve & +ve) that arose during hospital work that went unacknowledged in the past. Hidden jewels?	107	So it brings some emotions, positive and negative, so I'm sure I brought them to therapy and erm...and it helped me to either be aware of them or just to...to just...		bringing positive & negative emotions into therapy	INCREASED insight and self-awareness	Showing me the way
	108	<b>To be aware of?</b>				
Increased emotional awareness. Hidden jewels?	109	Emotions which I have at work which probably maybe I just sometimes hidden. Erm. Just aware of my feelings and....yeah.		awareness of feelings... sometimes hidden	INCREASED insight and self-awareness	Showing me the way
	110	<b>And what does the syringe do?</b>				
Syringe = flushing through so that medication can work. <u>Medical model.</u>	111	Syringe can be as a flush when you have....when you have...say, I don't know, injection. Mostly actually it's good because, as a flush, it flush through – there is antibiotic so it gives you just water just to dissolve and flush the antibiotic. So it's a good thing.	Syringe = work Nurse & Patient dynamic	to flush through and dissolve	THERAPIST as syringe / nurse	Showing me the way
	112	<b>It's a good thing.</b>				
Injection is painful = therapy	113	Yes. Syringe itself. Needle's a little bit worse. But still syringe itself it's rather a good thing.		needle's worse - but good	THERAPIST as syringe / nurse	Showing me the way
Nurse & patient dynamic?	114	<b>And...with...would....could you use....could you conceptualise that as something that happened to you in therapy?</b>				
And therapy was painful too.	115	I guess although sometimes I felt that the needle was there too ( <i>laughs</i> ). Yeah.		painful at times	THERAPIST as syringe / nurse	Showing me the way
	116	<b>(Laughs) So flushing...out.</b>				
Syringe = flushing out her toxins / Dissolving 'clots'. Toxins = Pebbles/jewels	117	Flushing out my, probably, toxins, I guess, from...from...or just dissolving which I thought that it cannot move.		flushing out toxins or dissolving stuck debris	THERAPIST as syringe / nurse	Showing me the way
	118	<b>Yes.</b>				
Syringe = injecting endorphins	119	And just through your system so, you know, it's like giving some endorphins to your vein.		giving some endorphins	THERAPIST as syringe / nurse	Showing me the way



or heparin to reduce stickiness 'clots' in the blood. Prevention of stuckness. Flexibility & fluidity. Therapy = flow.	120	It's kind of nice feeling or it just...it just...erm...giving a bit of water so it's not so...everything is not so...you know when blood clots too much....so it's like giving you heparin...so you can have a flow and nothing stick around your vein so you will not have a stroke. So it's like that. I think therapy is a little bit like that.		releasing stuck debris and increasing flow of energy?	THERAPY, painful but good	Showing me the way
Life-saving. Acknowl'nt of potential importance of Therapy.	121	And giving something like so...probably in some cases <u>it can save your life</u> , I guess.		it can save your life'	THERAPY, painful but good	Showing me the way
	122	<b>Yes. And supposing it had a needle?</b>				
Injecting with a needle - altho' painful it's also helpful.	123	Oh that...you know, that can be heparin. That's painful but that's helpful.		therapy can be painful but helpful	THERAPY, painful but good	Showing me the way
	124	<b>To make the blood less sticky.</b>				
painful, stinging, quick but also good for you & preventative.	125	Less sticky or just take out some blood to check it out, I don't know, give you some antibiotic quickly but that's <u>not painful</u> because it's going through cannula, so it's <u>not painful</u> . It's just a bit stinging.		not painful...a bit stinging	THERAPY, painful but good	Showing me the way
	126	<b>So in therapy, did you find it painful at times?</b>				
Didn't mind the short pain (deflection from wanting to feel?) 'cos she knew that it was...	127	Yeah, but you know, when you get, like heparin injections and, erm...have you ever had erm...it's quick and you...you mostly think that actually it's good for you so you... <u>you don't even feel it</u> .		You know 'it's good for you'	THERAPY, painful but good	Showing me the way
...preventing her from a worse, more painful situation.	128	It's just <u>short prick</u> and that's it...and...yeah, <u>therapy felt sometimes like that</u> , although...although you just don't concentrate on that small prick. You just know that, ok, that will <u>prevent me from dvt or you know, whatever</u> .		Painful but preventative	THERAPY, painful but good	Showing me the way
	129	<b>Prevent you from...from something worse.</b>				
	130	Something worse. Yeah.				
	131	<b>Life-threatening.</b>				
	132	Yeah. I mean not necessarily in such...er...extreme words but something...something which is painful, or let's say, like that. Yeah.				
	133	<b>So even with a needle, a syringe with a needle, although painful would also be beneficial for you in the end.</b>				
	134	Yeah. Yes.				
	135	<b>So I take it you didn't mind...</b>				
	136	No, actually.				
	137	<b>...when it was painful.</b>				
<u>Self as autonomous &amp; conscious rational agent.</u> <u>Shared power / control.</u>	138	No. No. And, you know, sometimes, it...it was <u>always my choice</u> , so it's not that, you know, <u>you can choose to have it or not</u> . It's <u>always your choice</u> , so you...they will ask you would you like that or not. <u>You always can say no</u> . <u>It's not that the therapist drives you</u> to give you heparin.		it was always my choice...it's not that the therapist drives you	CHOICE: sharing power & control Trust in therapist	Showing me the way

## Appendix 8

## A section of Kira's transcript showing codings and emergent themes

KIRA	Line	TRANSCRIPT	OBJECT	CODE	Emergent Descriptive THEMES	THEMES
<b>Coding:</b> Descriptives - Normal type		<b>Interviewer's interventions are in bold</b>		<b>Descriptive and in-vivo' quotes</b>		
Linguistics - <i>Italics</i>						
Concepts - <u>Underlined</u>						
From that cathartic moment every session involved crying. <u>Trust. Vulnerability w another.</u>	122	Something shifted in me and then it was like literally every session after that, I couldn't get through a session without completely breaking down.		something shifted in me	Overcoming fear & risking	Overcoming fear & risking
	123	<b>Yeah.</b>				
as thoughts & feelings would get triggered and she would move from being up one moment to being down the next moment like a 'zig-zag'. (roller-coaster). <u>Trauma: giving words to processes</u>	124	And...the...the hard thing was that those sessions, from then onwards, became like 'Whooh!'...like I'd talk about some days would be good and I'd talk about something and something would trigger inside me that I would think about something else and I would talk about that and then it would go down....and it was really like....(Her arm gestures a zig-zag)	zig-zag	From then onwards became like ...Whooh!	Talking & making links	Setting everything whirring
	125	<b>You've just described a kind of like zig-zag.</b>				
A sense that there was a torrent inside that being released	126	Yeah. And it was like I was trying to get everything out at once ....and it was all....and it was coming already to the end of my sessions.		..trying to get everything out at end	Rushing as the end was in sight	Setting everything whirring
	127	<b>Yes.</b>				
<u>Disappointment &amp; sadness to realise that. Attached. Mind focused.</u>	128	So I kind of.....when we did the wrap-up session I was really sad that we were doing it because I was like, 'I feel like I've just started'.		I feel like I've just started	sad to end	Setting everything whirring
	129	<b>Yes.</b>				
	130	But it just took me so long.		took so long	sad to end	Overcoming fear & risking
	131	<b>Yeah.</b>				
<u>Violent: took me so long to break me.</u> Wish to continue with same therapist. <i>Laughs - relief? Shame?</i>	132	To break. I could have had a year with the same person cos it just took me so long to break me and... 'Ppprrrrr!'...now I feel like I could be broken easily, like...(laughs).		Wish for same therapist. Took long time to allow self to be vulnerable	sad to end	Overcoming fear & risking
	133	<b>You use...you use the term like 'break'. Do you feel as though you were broken?</b>				
<u>There's a violence to her descriptions &amp; metaphors.</u> Would more therapy change <u>that?</u> She was the hard rock & was the therapist/therapy or self the hammer that split her hard rock & allowed her	134	Yeah I do. I really do. I feel like I was erm...(pause)...like I was this very...like a rock...and then a hammer came and hit me on the head and I split in half and the....the rock Kira stayed over here and the sensitive Kira that I know that I am and one that has been crying out for help hopped into my body and said, 'I...I need help...really desperately, like I'm just not...I'm not normal basically...like (laughs) 'Whooh!' not...I'm not right.	rock & hammer	Split in half Significant moment - defences down -> being vulnerable / sensitive & strong rock (2 parts of self)	Overcoming fear & risking	Overcoming fear & risking

sensitive & needy self to be found & emerge? <i>Again, a short laugh when she mentions 'normal'.</i>						
	135	<b>Mm.</b>				
<u>self-change and integration of both selves.</u> Hard, tough, strong vs soft & vulnerable	136	And there's still a <u>part of me of the rock person</u> that's in there that still, I think, will always be the <u>strong Kira</u> that I have always grown to be but the soft Kira or the Kira that needed help has come out a lot more and a lot <u>stronger than the other Kira before I came into it.</u>		soft, sensitive self became stronger	Increased acceptance & integration of selves	Becoming myself
	137	<b>Mm.</b>				
<i>Repetition of 'crying' to emphasise the extended length of time it went on for.</i> And not knowing why. Sense of therapy breaking her & causing an explosion	138	But...so I did feel like I was broken. I felt like, I don't know what it was but something...something moved...something triggered it and it was just like, 'Puhhh!' ....it was like an explosion and I remember that night just going home and just sobbing and just crying and crying and thinking to myself I can't, I don't even know what I'm crying about.	explosion	Sense of internal movement. Explosive cathartic moment. 'I did feel like I was broken'	Overcoming fear & risking	Overcoming fear & risking
	139	<b>Mmhm.</b>				
with hysterical crying	140	I'm just crying.			Overcoming fear & risking	Overcoming fear & risking
	141	<b>Mmhm.</b>				
Feeling like she'd been hit by a bus & for 2 wks feeling so much sadness coming out of her. <u>Cathartic reaction of physical release of stored emotions leaving her body</u>	142	I can't stop these tears because they just keep coming and, you know, like hysterically crying and then, just...remember waking up the next day and feeling like, 'ah...I've been hit by a bus'....and then for about 2 weeks after that I was just like, 'Ooooh I'm really not. I'm just not...good.' Like I knew I wasn't...it was all like...all this....coming out of me.....		Catharthis - 'hysterically crying' shock & suppressed emotions '...all this...coming out of me'	Overcoming fear & risking	Overcoming fear & risking
	143	<b>Mm.</b>				
Talking openly about how she felt & suppressed frustration - she started to feel better but also felt selfish..	144	....and I couldn't concentrate at work and....I just didn't....I wasn't....like I didn't know what I want with my life. I was in this like....horrible stage		Overwhelming 'horrible stage' after emotional shift	Overcoming fear & risking	Overcoming fear & risking
Increased clarity & increased well-being. <u>Little repetitions - reflecting w more clarity</u>	145	and then....things just felt like it...they just started getting clearer and...things started...the more I talked and the more I talked about this horrible hole I felt like I was in the more I...the more I started to feel better.		things starting getting clearer...the more I talked...ther more I started to feel better	Overcoming fear & risking	Overcoming fear & risking
Honestly disclosing her suppressed & deepest thoughts and feelings never spoken about before cos of protecting parents from feeling uncomfortable	146	And the more I started to openly talk about things and now, you know, things that I'd never ever talked to my mum about cos I'd be too scared of upsetting her or didn't want to hurt her feelings. I didn't want to make her feel like she was a bad mother or that my dad was a bad father or anyone was a bad person		talked openly about thoughts & emotions - suppressed in past to protect self & family	Overcoming fear & risking	Overcoming fear & risking
Aware of feeling disloyal but by taking a risk also recognising &	147	but the more I talk about it as much as I might upset them at the time I'm like, but I need this for myself,		recognised the need to unburden self	Overcoming fear & risking	Overcoming fear & risking
feeling the benefits of talking about all those suppressed thoughts & emotions	148	so I have to be a little bit selfish and say it because it makes me feel ten times better (laughs) about myself, about where I'm going and I can...speak and use the right words and stay calm and say,		unburdening self feels selfish yet empowering	Overcoming fear & risking	Overcoming fear & risking

## Appendix 9

## Table of 89 emergent themes

1. Accepting process is a long journey	2. Fearing delving into the past	3. Feeling stuck	4. Increased compassion & confidence
5. Becoming myself	6. Fearing contacting feelings	7. Feeling trapped in cage	8. Increased self-knowledge, self-acceptance
9. Building trust	10. Fearing deterioration without therapy	11. Feeling uncomfortable	12. Increased skills in understanding & managing emotions
13. Choice / control sharing	14. Fearing starting with new therapist	15. Feeling safe & cared-for	16. Increased thinking of links
17. Couldn't trust her therapist	18. Fearing the process of therapy	19. Finding & integrating	20. Increased self-belief, self-trust.
21. Couldn't overcome fear & risk exposure	22. Fearing therapist, expertise & relational qualities	23. Hoping for personal growth	24. Increasing knowledge & clarity
25. Depth gauging - Fear of positioning self with other	26. Fearing a male therapist	27. Idealising therapist rather than trusting	28. Interplay between therapy & life
29. Didn't feel safe with therapist's approach	30. Fearing discovery of self & other	31. Improving work situation	32. Journey /process of growth continues
33. Having difficulty in therapy	34. Fearing disloyalty & discovery	35. Increased choice & possibilities	36. Journeying together in a focused way
37. Feeling attachment loss at ending	38. Fearing loss of self	39. Increased insight	40. Lacking trust
41. Disappointing, wanted reassurance	42. Fearing self with therapist	43. Increased peace, less self-analysis	44. Less self-critical
45. Disappointing, wasn't as expected	46. Fearing shame	47. Increased positive thinking	48. Looking for a happier self
49. Doubting what therapy is about	50. Fearing vulnerability & self-exposure	51. Increased reflective ability	52. Making confusion clear
53. Feeling right time to end	54. Feeling cared for, heard, understood	55. Increased self-acceptance & understanding	56. Nearly becoming ideal self
57. Expecting to find peace of mind	58. Feeling confused & puzzled & looking for answers	59. Increased self-awareness, self-acceptance	60. Needing help
61. Expecting therapy, guidance & help	62. Feeling heard but not understood	63. Increased self-compassion	64. Continuing process of change
65. Expecting therapy, positive	66. Feeling motivated	67. Overcoming fear - not overcoming fear	68. Reaching emotional truth
69. PRIOR knowledge of therapeutic process	70. Feeling reassured	71. RUPTURE – doubting therapy	72. Showing me the way to go
73. THERAPIST as companion & guide	74. THERAPIST as container	75. THERAPIST as questioner, challenger	76. THERAPIST offered space to talk and think
77. THERAPIST as co-developer of relaxation skills	78. THERAPIST as puppy, soft, delicate & friendly - but not trustworthy	79. THERAPIST as reflector & questioner	80. THERAPIST as tracker of his thought processes, most imp
81. THERAPIST as facilitator increasing self-knowledge	82. THERAPIST as enabling speech	83. THERAPIST as collaborator	84. THERAPIST as illuminator
85. THERAPIST as fellow investigator	86. THERAPIST as equal friend	87. THERAPIST as colleague	88. THERAPIST as imparter of new ideas
89. THERAPIST as fellow thinker, meaning maker			

## Appendix 10

## The 89 emergent themes grouped into 7 clusters

### A. Holding Hopes and Expectations

- |                                |                                       |
|--------------------------------|---------------------------------------|
| 3. Feeling stuck               | 60. Needing help                      |
| 7. Feeling trapped in cage     | 61. Expecting guidance & help         |
| 23. Hoping for personal growth | 65. Expecting therapy to be positive  |
| 48. Looking for a happier self | 69. Having prior knowledge of therapy |
- 

### B. Holding Fears

- |   |  |
|---|--|
| 2. Fearing delving into the past          | 42. Fearing self with therapist                      |
| 6. Fear of contacting feelings            | 45. Feeling disappointed – wasn't as expected        |
| 10. Fearing deterioration without therapy | 46. Fearing shame                                    |
| 14. Fearing starting with new therapist   | 50. Fearing vulnerability & self-exposure            |
| 18. Fearing the process of therapy        | 22. Fearing therapist expertise & relationality      |
| 30. Fearing discovery of self & other     | 25. Depth-gauging – fearing positioning self w other |
| 34. Fearing disloyalty & discovery        | 26. Fearing a male therapist                         |
| 38. Fearing loss of self                  | 67. Overcoming fears vs not overcoming fears         |
- 

### C. Trust vs Non-Trust

- |   |  |
|---|--|
| 9. Building trust                             | 40. Lacking trust                              |
| 68. Reaching emotional truth                  | 41. Disappointment, wanting reassurance        |
| 11. Feeling uncomfortable                     | 49. Doubting therapy                           |
| 17. Couldn't trust therapist                  | 58. Feeling confused/puzzled – wanting answers |
| 27. Idealising therapist rather than trusting | 71. Rupture – doubting therapy                 |
| 33. Difficulty in therapy                     | 78. Friendly therapist – not trustworthy       |
- 

### D. Feeling Safe, Heard & Understood vs Feeling Not Safe

- |   |  |
|---|--|
| 15. Feeling safe & cared-for                | 80. Therapist as tracker of thought processes  |
| 54. Feeling scared for, heard & understood  | 82. Therapist as enabling speech               |
| 70. Feeling reassured                       | 21. Couldn't overcome fear & risk exposure     |
| 74. Therapist as container                  | 29. Didn't feel safe with therapist's approach |
| 76. Therapist offered space to talk & think | 62. Feeling heard but not understood           |
|   | 37. Feeling attachment loss at ending          |
- 

### E. Collaboration

- |   |  |
|---|--|
| 13. Choice/sharing control              | 83. Therapist as collaborator                  |
| 66. Feeling motivated                   | 85. Therapist as fellow investigator           |
| 75. Therapist as questioner, challenger | 86. Therapist as equal friend                  |
| 77. Therapist as co-developer of skills | 87. Therapist as colleague                     |
|   | 89. Therapist as fellow-thinker, meaning maker |
- 

### F. On a journey / Therapist as guiding light

- |  |  |
|--|--|
| 1. Accepting process is a long journey   | 72. Showing me the way to go                           |
| 28. Interplay between therapy & life     | 79. Therapist as reflector & questioner                |
| 32. Journey/process of growth continues  | 19. Finding & integrating hidden aspects of self       |
| 36. Journeying together in a focused way | 81. Therapist as facilitator increasing self-knowledge |
| 64. Continuing process of change         | 20. Making confusion clear                             |
| 73. Therapist as companion & guide       | 88. Therapist as impartor of new ideas                 |
| 84. Therapist as illuminator             | 16. Increasing thinking of links                       |
- 

### G. Client gains

- |   |   |
|---|---|
| 4. Increased self-compassion & confidence     | 43. Increased peace, less self-analysis               |
| 5. Becoming myself                            | 44. Less self-critical                                |
| 8. Increased self-knowledge / self-acceptance | 47. Increased positive thinking                       |
| 12. Increased skills understanding & managing | 20. Increased transferable skills, coping mechanisms, |
| 24. Increased knowledge & clarity             | 55. Increased self-acceptance & understanding         |
| 31. Improved work situation                   | 56. Nearly becoming ideal self                        |
| 39. Increased insight                         | 63. Increased self-compassion                         |
-

## Appendix 11 Example of excerpts of themes taken to peers for validity checks (a section relating to superordinate theme 2.3)

### Tom:

I...I found that the more I talked the more I was surprised by the fact that somebody wanted to listen. 25

To be heard – very important. 28

Very seriously I have been heard. (pause). 259

Being heard is also about being fed with time 278

### Mike

we were talking about the sort of conversations I enjoy having. 210

It's not the sort of conversation you get to have very often. 211

in depth thinking about stuff and talking and playing with ideas and if something occurs to me saying ooh! that's interesting and thinking about five other things, that it might be to do with something and stuff. 212

There are no coincidences but it's partly a coincidence in that it's over in the far corner, and one of the things that erm....one the conversations that we had in therapy was about the childhood thing. 226

### Dani:

I just wanted to talk to somebody anonymous, I suppose. 161

Well she just...she understood and she listened and she didn't judge me and she didn't offer me any solution...165

But the counsellor didn't judge me in that...or say anything in that way....she just sort of tried to work out.....(pause) 171

### Lisa

.... Just listening. Ok. Say something. No? Ok. It's fine. Em. But the fact that I wasn't being judged or, you know, being told off, as well like many guys did before, that was nice. 138-9

The fact that... and of course, that he would and...understand. I would see that he would *really understand*, not just saying, you know, just 'Oh yeah, yeah'. 208

felt he was listening to everything and over the few weeks I was surprised that would remember so many things. Cos that was weird. Like 'Oh he remembered that. He's really listening.' 216

Ah kind of he cared and he really wanted to help and he was trying to get to really know me and...yeah...just try to not hear but really listen 'cos there's a difference between the two. 218

Cos I was giving everything. Saying everything. So I knew I could trust that he wouldn't tell anyone or he wouldn't judge me really bad or...so yeah? 241

He was listening to me and he was helping me without asking for anything else except for money but, that's fine by me, so, of course there was difference. So hence the good building trust with guys that...yeah. 262

It was...it was nice. To put a bit of laughter in. Just to feel comfortable. 416-8

### Tess:

that was the thing that [therapist] was quite good at was picking out patterns of things and just reflecting back, you know, things that I said or how they made her feel. And she said, very early on, about this tightness and ccc thing and how, you know, that was the image that came into her head. 187-8

Erm. (pause) There are a couple of things which spring to mind. One is that I erm...wasn't having to talk to my husband all the time erm...'cos that had got into a real sort of...I mean, he's brilliant.....at sort of asking questions and helping and blah blah but it just got into one of those just going round and round situations where he was getting frustrated and I was getting frustrated ...so it kind of...that was really nice 'cos it kind of just took that out of our day to day living which was really good. 412-5

### Roza:

It was a part of therapy talking about my work because obviously I'm in it all the time. 105

I like my space so I think my therapist, she....she let me have my space so I liked that. She wasn't intrusive or...and I didn't treat her like my best friend or something like that and... 216

As a friend. Somebody who's helping me. 218

'cos you know, she just said....it just felt....it just felt...I mean I felt embarrassed but then it wasn't like she would judge me or anything. She wouldn't judge me, that was a good feeling. 369

### Pat:

Because she was....well...(pause)...because she was appreciative of me rather than judgemental certainly. So (laughs) where I might judge myself she would manage to find something to appreciate and remind me of that. 303-4

I don't think I've really talked to anybody honestly about my sex-life with my husband. I mean not in any great detail but I did one day talk about that. 335

## Appendix 12. Development of superordinate themes and related themes

This table illustrates the progression towards the development of final superordinate themes through the process of abstraction and subsumption; and the development of themes through re-labelling and integration.

Superordinate Theme 1 - Therapy is Dangerous – developed through abstraction from emergent themes			
Themes	Concepts and Quotations	Themes labelled from in-vivo quotations	
1.1 - Going into the jaws of the unknown	Fear of the process of therapy, loss of control, unpredictability		
1.2 - Dropping the mask that we wear	Fear of self-exposure : vulnerability, humiliation & discovery		
1.3 - It's the slippery slope	Fear of deterioration : mental, physical, financial & relational		
1.4 - Depth-gauging for undersea jagged rocks	Fear of positioning self with therapist		
Superordinate Theme 2 - Melting the Fears – (abstraction)			
	Concepts and Quotations		
		April-May, 2012 re-themed	June '12 re-labelled
Themes			Superordinate through subsumption; and re-labelled themes
	Safety, trust & nurturance	2. FORMING LAYERS OF EMOTIONAL CONNECTION	2. FEELING SAFE & UNDERSTOOD
2.1 Feeling safe & warm	<i>‘the sun in the sky’</i>	Feeling safe & warm	2.1 Feeling loved
2.2 Trusting the therapist	<i>‘Building trust....both way’s</i>	Blind Faith & building trust	2.2 Building trust together
2.3 Feeling attended to	<i>‘very seriously I have been heard’</i>	Feeling (nurtured) cared for, heard & understood	2.3 Feeling heard & understood
	Attention, non-judgemental listening, concern etc		
2.4 Starting to work together	Acceptance: <i>‘ It just felt good to talk to her’</i>	Establishing a mutual relationship of trust, respect, & control	
2.5 Holding onto doubt / defences / resistance	<i>‘Does she really know what she's doing?’</i>	Relinquishing fears & doubts vs holding onto defences	2.4 Overcoming fears & risking self-exposure & vulnerability
Superordinate Theme 3. Working Together became re-labelled as: Journeying together for personal discovery and change (through abstraction)			
		April-May, 2012 re-codings	June '12 re-labelled themes
3.1 Dynamic Relational Patterns(Joint Action)	<i>‘She showed me the way to go so I could find the key’</i>		3.1 Showing me the way to go
3.2 Pivotal Moments	<i>‘Something shifted in me’</i>	This theme was integrated into the others	
3.3 Continuing the Process	<i>‘Setting everything whirring and thinking’</i>		3.2 Setting everything whirring and thinking
3.4 Psychological Change	<i>‘I’m just in a different space’</i>		3.3 Becoming myself
3.5 Disappointments:	<i>‘I wanted more’</i>	This theme was integrated into the others	

## Appendix 13. Master table of themes and transcript location by each participant

This table lists all themes with links to participants' numbered quotations from their transcripts

Themes	Participant and Transcript Line Number									
	Mike	Jane	Tess	Ed	Tom	Roza	Dani	Lisa	Kira	Pat
1.1 Going into the jaws of the unknown	95-6		58				94	34-5	17	
	104		62				96	39	51-6	
	206		533				98	41	77	
	456						100	50	78	
	458						104	114		
								524		
1.2 Dropping the mask that we wear	455	123			14	368	6		38	
	456	138			360-2	433	8		40	
		422				464-6	27		58-64	
							31		77-9	
1.3 It's the slippery slope	85	43	14					48	203	
		168	153					51	270-1	
		170	156					53		
		179						69		
		208						73-4		
		386						116		
1.4 Depth-gauging for undersea jagged rocks	102	160-1	68		16-7	352	92	96	118-9	
	105-7		175		21-4	395	106	100-2	27	
	137		177		29	399	108	104	291-3	
	161-2				30-3	402	110	108	295	
	229				36	431-3	112	114	297	
	273				70	452-4	113-4	580	299	
	315				72	460-2	211	582	301	
						469	218	584	310-2	
						471	263		314	
						489			316	
2.1 Feeling loved	152	67	69	90	252	228	150	222	51	255
	186	162	71	92	440	261	154	252	253	258
	315	343	73	96-7		263	156	282	264	264
	318	345	409	227		278	159		274	274
	331	408	412	285		568	240-2			282
	395		420	289		576				292
2.2 Building trust together	292-3	11	175	190	36	159	117-9	229	273	60
	403	13	177	192	39	243	179	231	275	72
	405	15	181-4		154	331	224	233	277	88
	409	23	405		170	341	226	266	283	305
	414	31			304	357	228		285	318-22
	443	35			406	374/7	231-2		291-7	331
		57				409			308-16	334
		154				471				336
2.3 Feeling heard and understood	210	227	187-8	53	25	369	165	139-41	182	92
	211	331	412-5	55	28		167	196/8	548	94
	212	335		57	259		171	208-9	549	303-4
	226	382		58	262-4			211		
		413		60	278-9			215-6		



Themes	Participant and Transcript Line Number									
	Mike	Jane	Tess	Ed	Tom	Roza	Dani	Lisa	Kira	Pat
2.4 Overcoming fears & risking self-exposure	280-1	133	174	133	142	232	217	262	113-5	143
		167		167	237-8	353	237	57-8	134	181
		177		177	276		263	128	138	184
		179		179				290	148	189
		183		183				296	199	345
		196						396	429	
		200						408	431	
									453	
3.1 Showing me the way to go	188	2	214	29	327	5	65	44	105	50
	236	6	296	62-3	350	9	169	162	123	96
	295	7	302	118	352	38	173	163	211	100-1
	301	332	303-10	144	420	40	175	170	548-9	103
	393	333	326	146	430	42		177	557	116
	420		413	301-3		50		181	578	213
				319		60		345		241
				432		80		351		244
						239		435		246
						269		437		299
						525		554		
						535				
						539-41				
						558				
3.2 Setting everything whirring & thinking	299	238	252-4	64	248	555-6	126	457	124	131
	334	418	261	173			146	527	350	135-6
	361	424	265	270						221-3
	377		349							240
	471		356-7							
			538							
3.3 Becoming myself	74	285	97	339	134-5	22	42	398	136	155-6
	254	293	165	453	249	24	203	451	221	162-4
	258	431	272	461	255	250	269	454	240	169
	488		382	463	437	499	283	460	351-3	173
	506					508	330	521	393	175
	509						347		394	238
									483-4	364
									512	387
									520	391
									526	
									531	

Appendix 14. **Selected quotations for theme 1.1 from participants' transcripts** (a section of participants' quotations that link with theme: Going into the jaws of the unknown)

Participant and codings		Selected quotations
<b>TESS</b>		
<i>Hesitant</i>	58	(Sighs) Erm. Well somebody with...who was sort of young.
Fearing therapist's lack of expertise. Waste of her time and money.	62	Yes. Yes. And without the range of experience of having helped erm...sufficient range of people to be able to help me. If I'm honest.
<b>DANI</b>		
and picks up the alligator with the open jaw.	94	When I first met her and (picks up alligator with open jaw) I suppose it was going into the jaws of, you know, the unknown.
	96	I was going into very murky waters.
	98	And I didn't know what...I didn't know how it would work, even though I'd had therapy before, or whether I'd come out the other end alive.
Fear that she would be changed. Fear of losing self. Fear of discovery.	100	No. No. But whether I would come out the other end the person that I was,
<b>LISA</b>		
<u>There seems to be a violence about her choices. Huge swing btwn either/or, no degrees of change.</u>	34	and really um...erm...yeah? Em...yeah. Or you know it's this, we have a saying in [country of origin] I'm sure
<u>Damoclean: either or event - good or bad</u>	35	<u>it's when you cut something it's either good or bad. I mean it's going to do something.</u> Em....so.
<u>Damoclean: either or event - good/bad consequence - violent:broken</u>	39	Yeah...it's going to be broken. It will never be like before. Something. It will have a consequence.
<u>Powerless feeling. In hands of therapist.</u>	41	I don't have any power over....and that's the therapist's, I mean, job and hopefully a good one
<u>Wants a safe pair of hands</u>	50	You don't even know where all this is going
This male therapist 'eat her alive'	114	(Laughs) Yeah. He could eat me alive if he wants, kind of....
Had no knowledge of what to expect	524	Yeah. In a sense that I knew that if it succeeds I will feel better but I couldn't really tell at the time what to expect.
<b>KIRA</b>		
FEAR of self-change & what might emerge: Able to admit her fear now. Was there fear that she might not get a good therapist or that she might get a good one?	51	I think I was frightened and I feared what I would feel as I came out of it because I knew that counselling, and I knew different, not all therapists, but you know, good therapists, they...they help you work through... things you already know yourself.
fear of the unknown, self-change? Double-edged sword btwn +ve feelings & fear of feeling emotions.	54	I knew that when I came out of it I was going to be a different person because I knew that all these <u>thoughts</u> that I had which were all <u>relevant</u> and they were all, you know, <u>justified</u> ,
fear of self-change & decision-making	55	but I...I didn't know what course of action I was going to take or who I would become
	56	or would it change me as a person or would it change my thoughts towards my family? Erm.
Although fearful about the process of therapy & the changes involved, there was also a sense that there would be	74	Yeah. Yeah. Like the fear of...like I knew....I was intelligent enough to know that, at the end of this, there was going to be that black hole that I felt I was continually going into,
Fantastic or sad ray of sunshine to direct her decision-making.	76	And I didn't know what ray of sunshine it was going to be. Whether or not it was going to be an <u>absolute fantastic</u> one that I was like, 'oh god, you know, this is great. What am I thinking....of course I can get through this or I can speak....' or it was going to be a ray of sunshine, the thought that I went 'ok as much as this is really a <u>sad</u> thing to do I need to do this, this and this for me to be happy in my life.'
Change was inevitable	77	So...the discovery path was terrifying and I could see it and I knew it and I could...and they were my thoughts that would go on in my head as I knew what....
and this was the path that lead to change	78	I didn't know what was going to happen but I knew that the path would just...that was the path I was going to go down

Appendix 15. **Selected quotations for theme 2.3 from participants' transcripts** (a section of participants' quotations that link with theme: Feeling heard and understood)

<b>2.3 FEELING HEARD &amp; UNDERSTOOD</b>		
<u>Participant and codings</u>		<u>Selected quotations</u>
<b>KIRA</b>		
no-one understood her feelings. So transferred agg. onto T-mum.	182	It was never anyone understanding my feelings
Cherishes her thoughts about her therapist - internalised her.	548	...I can say I still think about things that she says, that she has said to me or, you know, little things that I think, 'Wow! She was really good. She helped me a lot'.
remembers things she said & how she helped.	549	You know, little things like that...that I think about that, you know, I will always cherish. Really some fond memories.
<b>ROZA</b>		
<u>but with non-judgement &amp; attunement, it became ok to do so.</u>	369	'cos you know, she just said....it just felt....it just felt...I mean I felt embarrassed but then it wasn't like she would judge me or anything. She wouldn't judge me, that was a good feeling.
<b>PAT</b>		
<u>Hesitant, difficult for her to articulate. Emphasis w repetition.</u> Maternal transference. Sense of spirituality.	92	Erm...but...erm...(pause) I could...(sighs)...I think I felt....I felt grateful for the level of attention that she erm...that she paid me which felt quite extraordinary.
Pertinent insight & attention from therapist with appreciative recipient	94	Erm. That she would. She would occasionally erm...she would occasionally say things which gave me insight which erm...made me realise that she attended to a lot of erm...what I'd said or a lot of what I'd felt and erm...
Felt safe because her therapist was non-judgemental & appreciative of her	304	So (laughs) where I might judge myself she would manage to find something to appreciate and remind me of that.
<b>DANI</b>		
Being heard & understood without judgement or solution.	165	Well she just...she understood and she listened and she didn't judge me and she didn't offer me any solution...
<u>Defining relationship by what it's not.</u>	167	...because I think the thing with friends is...you say something to them and they say, what have you got to be depressed about? Why are you so low? You know, you've got a lovely home, you've just had this extension completed, you know, you're going on a nice holiday, you've got a good job. What have you got to be miserable about? And the counsellor wasn't like that.
	171	But the counsellor didn't judge me in that...or say anything in that way....she just sort of tried to work out.....(pause)
<b>LISA</b>		
New embodied sense of not being judged or told off	139	But the fact that I wasn't being judged or, you know, being told off,
(like others in her past)	140	as well like many guys did before,
and really listened to. Not seeing any emotion (hate or love) and He was interested in helping her.	141	that was nice. So I think that helped through the weeks to....well, to give that eye more humanities somehow (picked up eye). Kind of something around it that was building. I couldn't....
Loved by him	196	Non-judgemental, I would say.
Didn't want an authoritarian figure or someone that would make her feel as child.	198	Cos I didn't want anyone to tell me, 'I told you so' or, you know, or those 'oh yeah but it's normal, like if you did that, of course that happens' this kind of vibe. I didn't want that
She felt that he understood her. <i>Emphasises 'really understand'</i>	208	The fact that... and of course, that he would and...understand. I would see that he would <i>really understand</i> , not just saying, you know, just 'Oh yeah, yeah'.
	209	And put me in one of those box and this is in his head what I have to do and act like that. So that....it was more a human feeling...
Hoping but wasn't expecting his humanity	211	...that...I wasn't expecting or I was hoping for it. Cos even though it's a professional relationship you still want some humanity in it.
Movie versions of uninterested therapists, automatic professional.	215	Just not a machine who's there, you know, to listen to you em....cos you always see movies where, you know, you have the therapist and the person is talking and either they're drawing funny things or making their food shopping or thinking about last night what they did. So.

## APPENDIX 16      **Superordinate theme 1 quotations used in body of work**

### **Superordinate Theme 1: Therapy as Dangerous**

#### **1.1 Going into the jaws of the unknown**

##### **Tess**

'young' 58

*'without the range of experience of having helped erm ..sufficient range of people to be able to help me'* 62

##### **Dani**

*'When I first met her and ..(selects alligator with an open jaw) ..I suppose it was going into the jaws of, you know, the unknown. I was going into very murky waters. And I didn't know what ..I didn't know how it would work [...] whether I would come out the other end alive [...] whether I would come out the other end the person that I was [...] it's a bit like swimming down the Amazon [...] it was the significance of the therapy and how I would be able to navigate.'* 94-104

##### **Lisa**

*'You don't even know where all this is going* 50 ..

*he could eat me alive if he wants'* 114

*'..it's when you cut something it's either good or bad. I mean it's going to do something [...] it's going to be broken. It will never be like before. Something. It will have a consequence.* 35

##### **Kira**

*'It kind of broke that barrier I needed to break.* 17

*'I think I was frightened and I feared what I would feel as I came out of it [...] I knew that when I came out of it I was going to be a different person .. but I ..I didn't know what course of action I was going to take or who I would become or would it change me as a person or would it change my thoughts towards my family?'* 51-6

#### **1.2 Dropping the mask that we wear**

##### **Tom**

*'you're not carrying the load. You're asking someone else to carry it.'* 361

*'To ask for help goes quite deep'* 362

*'I was anxious because I was about to open up to somebody I didn't know erm ..for all I know, you could be an enemy, and I could be showing you the map of my heart.'* 40

##### **Roza**

*'In the beginning ..I was like terrified. I was thinking, my god, because you will show your weaknesses and everything and it's embarrassing.'* 368

*'I was leaking my secrets.'* 454

*So it was a bit of a terrifying thing [...] The fear of not being caught [sic] by somebody* 464-6

##### **Kira**

*[...] I don't like to talk badly about people...' 38*

*[...] and especially not my family or my staff'* 40

*'the fear of ..admitting major things was scary to me ..and all those things that I knew I had to bring back up again ..that I managed to suppress for so many years ..but they were bubbling... aggressively inside of me and I knew that it was all going to just come to a break-down mode and ..it .. it had to be done 'cause it was making me crazy like I was turning into a strange person'* 58-64

*[...] the discovery path was terrifying and I could see it and I knew it and [...] I didn't know what was going to happen but I knew [...] that was the path I was going to go down and it was scary on how much I really didn't realise how bad the pot was boiling inside me'* 77-9

##### **Jane**

*'delving'* 123

*'I didn't want to talk about them.'* 138

*'Suggestions are good but when they make me quiz it's like, that, for me, didn't help'* 422

##### **Mike**

*'when we had that type of conversation it was like cartoon therapy thing and I was like ..sort of ..like a cliché of going to see an analyst.'* 456

#### **1.3 It's the slippery slope**

##### **Jane**

*'it's the slippery slope sort of thing'* 168

*'I suppose I think if this was an ambulance (picks up army/red cross truck) I suppose I was thinking that I was going to be going mad like some ..I'm going to end up in a mental institution 'cause I'm going off the rails. I was terrified of that basically'.* 208

*'if I come here, it means I have a problem'.* 179

*'when I used to leave I used to be questioning, questioning, questioning, questioning the whole thing. Like going away, just like, asking myself questions all the time. And actually made me feel ..sometimes made me feel worse'.* 43

*'The benefits weren't outweighing the costs'. 386*

#### Kira

*'I was very defensive. I didn't ..I was ..didn't want to have that breakdown. 270*

*'And scarily for myself where I would sit at the bus-stop and I would be thinking, 'I don't know. I don't even know what bus I need to get on.' 203*

#### Lisa

*'cause you're giving so much.' 48*

*[...] I needed it to be good to end up good otherwise it's a waste of time. Waste of energy. Waste of my sanity.' 69*  
*it could have ..could have ruined my ..my brain'. 116*

*Either you will be really lucky and you will have nothing or you will get everything broken and then you have to deal with that afterwards. 53*

#### Mike

*'would I still be coming in 5 years time and talking about the same thing?' 85*

### **1.4 Depth-gauging for undersea jagged rocks**

#### Tom

*'You don't know whether the person you're going to get on with or not, is going to understand you or not, whether they're going to tolerate you or not'. 16*

*'for the first few sessions it was really potentially dancing amongst wolves because I didn't know ...I had no idea what the person was'. 21*

*it's like depth-gauging' 32*

*[...] So it is actually finding out where the ..you know, the undersea, jagged rocks are' 33*

*[...] I would have to fit into some medical model or some psychological model or social model of interaction' 36*

#### Lisa

*'It represents the man and just the dangerousness about it that I had ..like really negative feelings. Being scared. 100-2*

*[...] kind of a ..ok the war is there.' 104 'this is the enemy' 108*

#### Dani

*'Well, I suppose I was the lock and she was the key and I didn't know whether she'd have the right key to open the lock'. 108*

*'She wasn't a soft pussy-cat'. 106*

*'on meeting you, you were very smiley and you made me feel very much at ease and I, I had no idea what the ..this was going to entail but I knew that it was part of a research so ..but I felt totally at ease. 'When I met her, I just sort of thought she's not ..she wasn't as friendly and as open and as ..and I didn't feel relaxed within her company'. 113-4*

*'a bit scared [...] apprehensive' 92*

*'stand-offish' 263 ' she was more of the authoritative figure' 211 'I was the putty in her hands' 218*

#### Kira

*'Ah, I don't think she's offering me really very much. I'm not sure she's actually very good.' 277*

*'I knew I was doing it right from the start but I was so scared about breaking down and crying and all that, that I just sat there like ..and ..and I can remember clearly like ..almost ..gaze ..like gazing out because I didn't want to be really interacting. I didn't wanna look, you know, at the counsellor in the eye, in case, you know, she gave me a look, or a sad look that might make me upset. I would gaze out of the window or I would look around the room or I would, you know, get ..sit ..move around my chair.' 118-9*

*'I don't know why I'm drawn to it but I feel like it's almost like a ...a ...something of the night [...] sneaky, like ..a little, you know, like ..when you think of a black ..a dark, black night and you see a little cat sneaking along. Like, I feel like that was me. 291-3*

#### Roza

*'in the beginning I tried to ..I assess people a little bit just to see where to, you know, how to put myself in ..in that relationship'. 402 'sag' 409 'weird things' 419*

*'I think there was my protection for me too. I'm not going to, you know, throw something important for me and then she just freak out. Or I don't know, or just, be surprised or ..and also I need to ..I was getting ready for myself to, you know, show my weaknesses which is not nice to show them. Erm ..it's a ..it's sometimes humiliating'. 431-3*

#### Jane

*'I was always thinking what does she think of me? What does she actually think of me? And I was often thinking that. Erm...and, you know, I really wanted to say: What do you really think? Do you think I'm crazy? What do you really think of me?' 160*

Ethical Approval (Appendix 6)

Client Information Sheet (Appendix 1)

Consent Form..(Appendix 2)

Object Tray (Appendix 3)

Demographics of participants (Appendix 4)

Interview Schedule (Appendix 5)

Audio-recordings (on 2 thumb-drives)

Transcripts (filed on secure computer)

Codings of transcripts showing theme development on Excel: examples (Appendices 7 & 8)

Table of 89 emergent themes (Appendix 9)

89 emergent themes grouped into 7 clusters (Appendix 10)

Examples of data taken to peer groups for theme matching (Appendix 11)

Master table showing emergent themes with superordinate themes (Appendix 12)

Master table of themes & transcript location for each participant (Appendix 13)

Selected quotes for themes from participants' transcripts: examples (Appendices 14 & 15)

Quotes used in write-up for each theme: example (Appendix 16)

Reflexive Diary